PSYCHOLOGISTS' INCORPORATION OF CULTURAL DATA IN PSYCHOTHERAPY: AN EXPLORATORY STUDY

A Dissertation

by

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ABSTRACT

Culture has been shown to have a significant impact on health care disparities and, more specifically, in the treatment of mental health. As a result, research has highlighted the importance of cultural competence in all stages of psychotherapy. The need for cultural competence has garnered much attention allowing its research to proliferate and inform guidelines for mental health treatment. However, despite the known importance of cultural competence there is a dearth of knowledge informing how a mental health professional should incorporate cultural data into their psychotherapeutic practice. This creates large problems for the field as it leaves many professionals without a sound model for the application of cultural competence.

This study was developed in an effort to bridge existing gaps in cultural competence research. Due to the lack of knowledge about the process by which cultural data is incorporated into psychotherapy this study utilized a qualitative phenomenological approach to better understand the phenomena. Eight licensed and practicing psychologists were recruited for interviews that occurred in person or through Skype video conferencing. Participants were asked 15 questions that were developed as part of a semi-structured interview protocol. Interviews were recorded using a digital audio recording device. Data analysis involved transcribing all participants' interviews, coding the validated transcripts for independent units, and organizing these units into categories, subcategories, and subsets providing a description of the participants' lived experiences. Results indicated the emergence of three major categories: the nature of cultural competence, therapist responsibility to bring culture to the forefront, and application of culture. Within the first

category two subcategories emerged: willingness to learn, and knowing what you do not know. The second subcategory contained two parts, A and B. Subcategory two-A, knowing what you do not know, showed a development of four subsets that provided further description of the nature of cultural competence: asking the client, no assumptions, cultural data gathered at intake and throughout, and in-depth knowledge from interaction/experiences. Subcategory two-B, not knowing what you do not know, described the limits on acquisition of cultural competence and did not produce any subsets. The second major category did not produce any subcategories. The third and final major category was shown to have three subcategories: assessment, intervention, and outcome evaluation.

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CHAPTER I

INTRODUCTION

The purpose of this study is to explore how psychologists incorporate cultural data into case conceptualization and overall psychotherapeutic practice. Several strands and findings in the literature underscore the importance of the incorporation of culture in psychotherapy. First, culture is integral to psychotherapy. Draguns (1973) identified culture as a silent partner in psychotherapy, suggesting its ubiquity but typically overlooked contribution to the process and outcome of this endeavor. Unless clinicians grapple with culture's role in psychotherapy, they handicap themselves in facilitating meaningful therapeutic change. Second, among their various characteristics, humans are cultural beings. Culture pervades all aspects of human existence, implying individuals develop within a cultural context, and therefore, culture manifests itself in each client's psychological presentation. Therefore, ascertaining this manifestation of culture is critical to formulating a sound case conceptualization (Ridley & Jeffrey, in press). Third, mental health care disparities and racism in the mental health delivery system are firmly established. Considerable evidence has been found of inequities in assessment and diagnosis, selection of interventions, assignment of clinicians based on status, premature termination, and dissatisfaction regarding the treatment experience of ethnic minority consumers (Cook, McGuire, &Miranda, 2007; Cook et al., 2014; Ridley, 2005). Additionally, literature discussing health and mental health care implicate race, ethnicity, and culture as common factors for observed disparities. Other diversity factors such as gender identity and sexual orientation have also been highlighted as factors for

health and mental health disparities found in transgender/gender variant and bisexual individuals as well as women (Conron, Mimiaga, & Landers, 2010; Gleason et. al., 2014; Kattari, Walls, Speer, & Kattari, 2016). This emphasizes the importance of cultural competence in psychological practice (Blanco, et. al., 2007; Dankwa-Mullan et. al., 2010; Stockdale, Lagomasino, Siddique, McGuire, & Miranda, 2008).

Fourth, building on the above issue, cultural competence in psychotherapy remains an elusive and confusing construct (Ridley & Shaw-Ridley, 2011). Despite the burgeoning literature on cultural competence, there remains a lack of agreement in the definition and components of the construct (Huey, Tilley, Jones, & Smith, 2014). Furthermore, none of the three major models of cultural competence have been demonstrated to contribute to therapeutic outcomes. These difficulties not only fail to show a relationship between cultural competence and therapeutic change, they fail to provide clinical guidance for the gathering, interpreting, and synthesizing of cultural data.

In light of the aforementioned four considerations, this study seeks to address an important gap in the literature: an understanding of the gathering, interpretation, and synthesis of cultural data in psychotherapy. This void leaves clinicians to rely on their own construed approaches to integrate cultural data into their interventions, yet without the support of research or empirical evidence. The objective of this study is to explore the process by which psychologists' gather, interpret, and synthesize cultural data into psychotherapeutic interventions. This investigation is an effort to better understand the phenomenon of cultural competence in psychotherapy and bridge the conceptual gaps in the literature. Two research questions were developed to help achieve this objective: 1) how do current and licensed practicing psychologists incorporate cultural data into their

psychotherapeutic practices and 2) how does their incorporation of cultural data inform the overall psychotherapeutic process as well as outcome evaluation?

CHAPTER II

REVIEW OF LITERATURE

II.1 Comprehensive Definition of Health

Conceptualizations of health have been studied for millennia. However, its operationalization has been a challenge because of it subjective nature. Lerner (1973) describes health as being multidimensional and entrenched within a community. He states, "…the wellbeing of any individual is intimately associated with the health of his community" (Lerner, 1973). The development of a comprehensive health definition began with The World Health Organization's (WHO) definition of health as "...a state of physical, mental, and social well-being and not merely absence of disease or infirmity" (1948). Since then an expansion of knowledge within the social science field has led to a better understanding of social factors and their impact on health, resulting in a shift of discourse from a reductionist view of health to one more holistic (Braveman, Egerter, & Williams, 2011).

The federal government followed suit with this comprehensive conceptualization of health in 2010 by developing Healthy People 2020 led by the Office of Disease Prevention and Health Promotion. Healthy People 2020 aims to address nationwide health priorities. In large, its goals include attaining quality lives free of preventable disease, disability, injury, and premature death as well as creating social and physical environments that promote good health (U.S. Department of Health and Human Services, 2016). Healthy People 2020 has identified a need for research on the societal determinants of health which are defined as, "...the social, physical, and economic environment in which people are

born, live, work, and age" (Office of Disease Prevention and Health Promotion, 2016). Social determinants include interactions with family, friends, coworkers, and cultural attitudes, norms, and expectations (U.S. Department of Health and Human Services, 2010). Healthy People 2020 represents the dynamic change occurring in the concept of health indicating the necessity of awareness and importance of sociological and cultural factors on health status.

II.2 Health and Mental Health Disparities

Health and mental health disparities, as well as health and mental health care disparities have been well documented in the literature **(**Atdjian & Vega, 2005; Bell & Mehta, 1981; Constantine & Sue, 2007; Cook et. al., 2014; Killbourne et. al., 2005; Stockdale, Lagomasino, Siddique, McGuire, & Miranda, 2008**).** Health and mental health disparities refer to higher rates of mental and medical illness including mortality that is experienced by one population group relative to another. Health and mental health care disparities refer to the differences between groups in health insurance coverage, access to and use of care and the quality of care received (Ubri & Artiga, 2016). Despite considerable national efforts to address these issues, they persist as serious and significant problems (Mayberry, Mili, & Ofili, 2000; McGuire, Alegria, Cook Wells & Zaslavasky, 2006; McGuire & Miranda, 2008; Safran et. al., 2009; Samnaliev, McGovern, & Clark, 2009).

Existing mental health care disparities among cultural groups include premature termination of mental health care services as indicated by treatment termination rates of White European Americans at 30% and rates for culturally diverse individuals at 50% (Day-Vines, et. al., 2007). Additionally, African Americans have been found to seek mental health treatment less often than Whites for major depressive disorder (Sussman,

Robins, & Earls, 1987). Differential treatment among ethnically diverse individuals have also been documented- compared to Whites, ethnically diverse individuals are more likely to receive differential treatment across various aspects of mental health care. Studies have also shown that clinicians tend to provide more severe diagnoses to ethnic minorities. African Americans tend to be frequently diagnosed with schizophrenia despite having symptoms associated with an affect disorder (Robinson & Morris, 2000).

Mental health disparities encountered by ethnic minorities include higher rates of lifetime PTSD prevalence with African Americans when compared to Whites. Similarly, African Americans have a higher risk of developing PTSD once exposed to a traumatic event (Roberts, Gilman, Breslau, & Koenen, 2011). A study conducted by Jimenez, Alegria, Chen, Chan, and Laderman (2010) shows significantly higher rates of any 12-month psychiatric disorder among U.S. born and immigrant Latinos when compared to non-Latino Whites. Additionally Gonzalez, Tarraf, Whitfield, and Vega (2010) found African Americans to have higher rates of reported general functioning role impairment when compared to Whites. Asian subgroups examined in this study (Chinese, Filipinos, and Vietnamese) who met criteria for 12-month major depressive disorder episodes also reported lower general functioning role impairment relative to Whites. Higher odds of recurrent major depressive disorder episodes were also found within Mexican, Puerto Rican, and African American communities when compared to Whites (Gonzalez, et al., 2010). As a result of these numerous and longstanding disparities, a supplement to the U.S. Surgeon General Report cites loss of health and productivity for ethnic minorities as an outcome of unmet mental health needs (Department of Health & Human Services, 2001). Rates of mental illness are also higher among gay, lesbian, bisexual, and

transgender persons. Burgess, Lee, Tran, and van Ryn (2007) found higher levels of distress, greater likelihood of a depressive or anxiety diagnosis, and more substance use among LGBT individuals. Consequently, the Federal Collaborative for Health Disparities research has chosen mental health disparities as one of the four major issues that are in need of national research attention (Safran et. al., 2009).

Similar to mental health care, disparities in care of medical illness also persist. Increasing minority populations within the U.S. and naturally resulting variances in health needs point to the integral role culture plays in health. Increased attention on the impact of culture and race on health has resulted in numerous studies citing the outcomes of health care disparities due to variances in culture (Egede, 2006; IOM, 2002; Mayberry, Mili, & Ofili, 2000; Samnaliev, McGovern, & Clark, 2009; Trivedi & Ayanian, 2006). One sector in which health care disparities appear is in the overrepresentation of uninsured minorities. Latinos comprise 13% of the U.S. population but make up 25% of Americans without insurance. Even so, those individuals with insurance and access to health care show lower utilization rates of cardiac procedures, prescription of medications for pain management, transplantation referrals, and the use of Medicare covered services like mammograms and immunizations, depicting persistent and pervasive health care disparities (Betancourt, Green, Carillo, & Ananeh-Firempong, 2003). For those in the LGBT community, a study found lack of education about LGBT issues and homophobia to influence the services provided. LGBT individuals were denied services, discouraged from discussing sexuality and gender issues with their provider, and were secluded within residential treatment centers (Willging, Salvador, & Kano, 2006).

Research also shows the existence of health disparities that continue to pervade society. The National Institute of Health (2006) affirms the presence of health disparities among African Americans, Hispanics, Native Americans, Alaska Natives, Asian, and Pacific Islanders specifically related to the burden of illness and death. Data indicate that individuals from minority groups suffer disproportionately more from cardiovascular disease, diabetes, asthma, and cancer (Betancourt, Green, Carillo, & Ananeh-Firempong, 2003). More specifically, African Americans have been shown to have a death rate that spans across age ranges and is 30% higher than that of Whites. Similarly, mean ages of ethnic minorities are also lower than that of Whites. The mean age of Whites is at 37.7 years while those of American Indians, Native Hawaiians and other Pacific Islanders, Hispanics, African Americans, and Asians are at 28.0, 27.5, 25.8, 30.2, and 32.7 years respectively (Williams, 2005).

Despite the proliferation of interest and research involvement in health and mental health as well as health and mental health care disparities, significant differences in health and mental health status continue to exist. Within mental health, it is recognized that the experience of significant social and economic deprivation among racial and ethnic minorities can influence the distribution of psychopathology (Jackson et. al., 2004). Outcomes of this deprivation are evident in rates of lifetime mental illness prevalence. Among American Indian Tribes prevalence of any psychiatric disorder (50-54% for men, 41-46% for women) is higher than the overall U.S. population (44% for men, 38% for women). Additionally, although Hispanics, African Americans, and Asians show lower rates of lifetime prevalence the risk of illness persistence and resulting disability from mental disorders is higher than that of Whites (Primm et. al.,

2010). Furthermore, a general overrepresentation of racial and ethnic minority individuals in state-operated mental institutions and facilities has been documented (Wade, 1993).

Continued health disparities include racial and ethnic minorities facing higher rates of cancer, heart disease, and diabetes compared to Whites (Nelson, 2002). A report produced by the Center for Disease Control and Prevention (CDC) (2013) indicates that Non-Hispanic African Americans had higher rates of colorectal cancer compared to other ethnic minorities and non-Hispanic Whites. The same report shows rates of HIV diagnoses eight times higher for African Americans when compared to Whites. For Hispanics and Native Hawaiians/other Pacific Islanders, this difference is twofold when compared to Whites (CDC, 2013).

The body of evidence for disparities in the healthcare system is strong. High rates of comorbidity have been shown to lead to worse mental and physical health outcomes (Goodell, Druss, & Walker, 2011Trivedi et. al., 2015). This combined with the increase in differential use of mental health services among racial and ethnic minorities first observed in the 1980s and 1990s indicates that the existing health and mental health disparities cannot be overlooked (Wade, 1993).

II.3 Culture

Lerner (1973) describes health as contextual such that an individual's community impacts their view of wellbeing. In this regard, culture can be considered as an integral component of communities. Although various conceptualizations of culture exist, a commonly used and accepted construct among anthropologists refers to culture as a system that relates human communities to their ecological settings (Keesing, 1974). Rohner (1984) builds upon this definition to view culture as a system with shared symbols and meaning.

A core component of this definition is that culture lies within the "equivalent and complementary learned meanings." Equivalent in this context refers to approximation, as no two individuals are likely to hold the exact same meaning (Rohner, 1984). Triandis (2000) expands on this conceptualization by describing culture as, "...tools and ideas that are shared and transmitted to succeeding generations because they were once practical at one time." Triandis goes on to describe culture as having both objective and subjective components. Objective components are defined as physical entities developed by the culture such as roads and buildings. Subjective components consist of familial roles, communication patterns, and affective styles (Betancourt & Lopez, 1993). The increased globalization of our communities and the resulting explosion of communication and relationships between people of various cultures indicate the importance the subjective components of culture have on an individual's well-being and the treatment they receive by health professionals.

II.4 Psychology, Culture, and Mental Health

The United States has a unique population such that cultural stratification allows individuals from various cultural backgrounds to live together within the same community. Currently 25%-30% of the U.S. population self-identify as belonging to ethnic or racial minority groups. It is predicted this number will rise to 47.5% by 2050. Additionally, identification to an LGBT identity is increasingly more common among younger populations (Gates, 2014). Changing diversity demographics within the U.S. population is likely to lead to larger social and racial disparities in health. This results in a greater need for health professionals, including psychologists, to understand culture and how it plays a role in an individual's well-being (Yali & Revenson, 2004).

Culture is comprised of tools and ideas that are shared and learned between a group of people over generations (Fischer, 2009; Triandis, 2000). Ideas shared between individuals can also include their perception of mental health. As such, culture has been shown to have strong impacts on mental health by manifesting itself in symptom presentation, communication of these symptoms, coping styles, and willingness to seek treatment (Eshun & Gurung, 2009). Castillo (1997) describes several ways in which culture influences mental health- through the individual's personal experience of the illness and related symptoms, the expression of their experience of the illness and its symptoms, the interpretation and diagnosis of symptoms expressed, and the treatment and outcome of the mental illness. Cultural factors influence not only the individual but other various aspects of mental health care including also the provider, the assessment process, and intervention utilization (Hwang, Myers, Abe-Kim, Ting, 2008). Snowden (2003) suggests bias can occur in mental health treatment as a result of unfounded assumptions becoming normative beliefs shared by multiple individuals about specific cultural groups. These assumptions can manifest in treatment expectations such as perceiving minority clients to be unreceptive, hostile, naive, and superstitious to treatment. In an effort to minimize bias and its influences Kirmayer, Simpson, and Cargo (2003) suggest mental health be recognized as a "tradition" such that it encourages a sense of de-centering and rethinking of the exchanges in values that occur in treatment.

The increased attention on diversity and culture in research poses great advantages for psychologists to contribute to the field of mental health. As a field, psychology has had strong involvements in the development of theories of culture and cultural competence (Sue, Zane, Hall, & Berger, 2009). This has resulted in numerous psychological studies

addressing various aspects of cultural competence in mental health (Griner & Smith, 2006; Kirmayer, 2012; Lopez, 1997; Sue, 2001; Whaley & Davis, 2007). This extensive background in cultural research provides psychologists a unique opportunity to address mental health in a comprehensive and culturally bound context.

However, existing research on culture and mental health does not provide the necessary information for the effective integration of cultural data into the psychotherapeutic process. Without understanding how practicing psychologists integrate culture into their interventions, it is difficult to posit the challenges they face and how this may contribute to health disparities. More importantly understanding this process of cultural incorporation can highlight gaps existing in effective cultural competence education, research, and training.

II.5 Cultural Competence

Continued changes in the diversity of the United States has prompted a shift in attention to the well-being of ethnic minority individuals and diversifying health needs (Ridley, 1985; Sue, Zane, Hall, & Berger, 2009). Rising out of this concern and coming to the forefront of counseling psychology research is cultural competence. Although the literature fails to provide an applicable definition of cultural competence, Sue (1998) outlined the concept as a general belief that providers should not only be able to appreciate and recognize other cultural groups, but also be able to provide effective treatment within a cultural context. Several reasons suggest the use of cultural competence in mental health. First is the aforementioned diversification of the United States population. This diversification has led to racial and ethnic changes in the labor force, in the number of ethnic and racial minorities contributing to government programs such as social security

and pension, as well as in the demographic of schools and places of higher education. Second, although improved, there still exists a monocultural nature of training such that multicultural and cross-cultural competence are seen in isolation and not fully integrated into treatment. It is important to note, however, that the past two decades have shown a considerable increase in multicultural and cross-cultural competency research. Their lack of integration into treatment can be seen more as a result of the literature's failure to provide practical and applicable integration suggestions. Third, the provision of mental health services occurs within a microcosm of societal values and events. Values, beliefs, and attitudes held by the larger society can easily be reflected in treatment. Additionally, events occurring in larger political, educational, and other institutions have the capability to impact personal lives (Sue, 1992). As literature on minority well-being has accrued over the years and accompanying recognition of the burgeoning need for cultural competence has grown, the U.S. Department of Health and Human Services (2001) has taken note of the salience of this phenomenon and defined cultural competence as "...a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professions that enable work in cross-cultural settings." The creation of this definition is a testament to the pervasive importance cultural competence plays in not only mental health but in the overall well-being of individuals.

Culture within mental health is an especially important consideration for minority patients being treated by the majority group (Whaley & Davis, 2007). Culture has been found to influence the experience, expression, course, and outcome of mental health problems. It has also shown to have impacts on world view, help seeking behavior, and responses to health promotion, prevention, and treatment interventions (Kirmayer, 2012;

Lo & Fung, 2003). For clinicians, cultural factors have been found to impact assessment validity, the development of a therapist-client rapport, therapeutic alliance, and treatment effectiveness (Sue, 1998). As a result cultural competence has been deemed critical to the promotion of effective mental health care treatment to diverse populations (Sue, 2006).

II.5.1 Conceptual Inadequacies of Cultural Competence

In response to the cultural needs of a diversifying population, various conceptualizations of cultural competence have been developed. Unlike other psychological or cultural concepts, cultural competency is skills based rather than philosophical or ideological in nature (Sue, 1998). Despite existing research on cultural competence and its uses, there continues to be a lack of consensus among psychologists regarding the definition and components of cultural competence (DeAngelis, 2015). Additionally, more critical to the argument is the inadequacy of its conceptualization. More specifically, the implementation of existing cultural competence guidelines into psychotherapy has been hindered due to the lack of a conceptual framework in its organization of its various dimensions (Sue, 2001). These conceptual inadequacies are described as follows: first, the development of pragmatic and tangible strategies for the attainment of cultural competence requires its purpose to be defined. Without its purpose, the goal for each strategy, and thus the strategy itself, cannot be appropriately developed. Second, the purpose of cultural competency must include the desired outcomes. Once these have been established, necessary strategies to achieving the outcomes can be developed. Currently, cultural competence lacks a definition of its purpose (Ridley, Baker, & Hill, 2001). Sue (2001) proposes therapeutic gain, defined as the purposeful and positive change that is brought on by the therapeutic process as one of

the two purposes of cultural competence. Ridley et al. (2011) suggest that therapeutic gain must be the superordinate purpose of cultural competence if it is to be further developed and integrated into psychotherapeutic interventions. However, similar to the purpose of cultural competence, the goals of therapeutic gain have not been expanded upon. This creates failures in how the literature addresses individual or organizational attainment of cultural competence (Brach & Frasiresctor, 2000). Given this paucity of research, there is a great need to examine the components and process of cultural competence implementation into psychotherapeutic interventions (Kirmayer, 2012).

In an effort to combat the discrepancies in the literature Sue et. al. (1982) pioneered the notion of specific cultural competencies that ought to be required and utilized in counseling. As a result, the Tripartite Model of Cross Cultural Competence has come to be the most recognized and utilized framework among psychologists and other health professionals. The framework emphasizes cultural awareness/beliefs, cultural knowledge, and cultural skills as qualities a culturally competent psychologist must possess. Cultural awareness refers to an awareness of personal beliefs and values that may impact the client and treatment. Cultural knowledge is the amount of information about the client's culture, worldview, and expectations for counseling a clinician possesses. Cultural skills refer to the ability to provide interventions that are culturally sensitive and relevant (Sue, 2001; Sue, Zane, Hall, & Berger, 2009). The concept of knowledge, skills, and awareness as necessary requirements for cultural competence has taken the literature by storm, resulting in three models of cultural competence that are commonly used within mental health.

II.5.2 Models of Cultural Competence

Huey, Tilley, Jones, and Smith (2014) outline three models of cultural competence commonly utilized in mental health. The first, skills-based models, views cultural competence as a combination of self-awareness and knowledge of other cultures and a cognizance for how these values impact the therapeutic relationship. For instance, Sue et. al. (1982) discuss the importance of a culturally competent psychologist being able to understand the manifestation of communication differences in therapy and in the expression of symptoms as well as the relation of cultural cues to verbal and nonverbal actions in a therapeutic context. The literature bolsters this argument by recognizing that the skills needed to effectively work with culturally diverse populations must go beyond the repertoire of counseling skills that are widely accepted in the profession (Pedersen, 1978). That is, the culturally competent psychologist must not only be able to use broad skills that facilitate therapeutic change, but also be able to facilitate that change with respect to the client's cultural worldview and the implications it may have on the therapy process. In support of this, Sue et. al. (1992) developed specific skills-based characteristics that they argue define a culturally competent psychologist- a) awareness of personal assumptions, values, and biases b) an understanding of the client's worldview and c) an ability to create interventions that are culturally appropriate.

The second model of cultural competence, adaptation models, has received the greatest amount of attention in the literature. Adaptation models implement adjustments to service delivery, therapeutic processes, and the elements of treatment in an effort to be more culturally congruent with the client and their worldview. Adaptation models are categorized into either surface structured or deep structured. Surface structured adaptation models are used to improve the acceptability of interventions by modifying superficial

characteristics of the treatment such as translating materials and using the client's language. Deep structured adaptation models pinpoint the cultural values and traditions that impact the client's perception of a disorder (Huey, Tilley, Jones, & Smith, 2014). One popular framework developed by Bernal, Bonilla, and Bellido (1995) and which has now been integrated into various evidence based treatments, involves adaptations to eight different elements of treatment - language, persons, metaphors, content, concepts, goals, methods, and context. The first element pertains to using language that is culturally similar or appropriate to the client. The element of persons refers to ethnic and racial similarities or the discussion of racial issues in session. Adapting elements of metaphors suggests the use of symbols or concepts that are culturally familiar to the client. The element of content refers to the application of cultural knowledge while concept is the discussion of the problem in line with the client's cultural beliefs and worldview. The element of goal refers to collaborating with the client such that their goals for therapy are congruent with their cultural background. Methods refer to the development of treatment that is compatible with the client's culture. And lastly, context refers to the consideration of contextual influences such as acculturative stress, social supports, country of origin etc. that my impact the therapy process.

Process-oriented models contrast with the two previously described. Rather than focusing on therapist or treatment characteristics, the process-oriented model highlights the mechanisms underlying treatment. Specifically, it emphasizes cultural meaning, its attachment to specific behaviors or treatment contexts, and the dynamic and flexible nature of culture within therapy itself (Carpenter-Song, Schwallie, Longhofer, 2007; Huey, Tilley, Jones, & Smith, 2014). For example, a process-oriented model of cultural competence

proposed by Lopez (1997) highlights the therapist's ability to shift between their own cultural perspective and that of their client. They argue that for a clinician to be culturally competent, they must be able to integrate the client's cultural worldview into their own worldview. Lakes, Lopez, and Garro (2006) suggest that by doing so, the clinician defines the problem within the client's worldview thus engaging the client in treatment by treating and addressing the issue using both perspectives.

Although these models have been well developed and utilized in mental health treatment several limitations exist, hindering the effective integration of cultural competence in psychotherapy. Huey, Tilley, Jones, and Smith (2014) expand upon these limitations in their study. First, they suggest that the majority of empirically based cultural competence research utilizes only the adaptation model. Griner and Smith (2006) provide evidence for this by their discussion of the exponential increase of empirical reports of culturally adapted mental health treatments. Several randomized control trials that address the impact of cultural competence on treatment outcome utilized techniques similar to those described in adaptation-models (Lee et. al., 2013; Naeem, et. al., 2015; O'Mahen, Himle, Fedock, Henshaw, & Flynn, 2013;). Second, of the existing randomized controlled trials (RCT) on adaptation models, outcomes have shown mixed results (Alvidrez, Snowden, Rao, & Boccellari, 2009; Ginsberg and Drake, 2002; McCabe and Yeh, 2009; Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015). In some cases, studies have shown positive impacts on ethnic and racial minorities when using culturally adapted treatments while others depict no change in outcomes. Relatedly, cultural competence models have been critiqued for their static view of culture. Consequently, while attention has been given to between-group differences, a dearth of emphasis is placed on within-

group differences. While process-oriented models do address these dynamics, few RCTs assess this approach. Research examining process-oriented models generally require access to counseling sessions, reports, or audio/video tapes, creating feasibility and accessibility issues for investigators. (Carpenter-Song, Schwallie, Longhofer, 2007; Wendt & Gone, 2011). Huey, Tilley, Jones, and Smith (2014) point out one additional important limitation in the study of these models. Research in which ethnicity is used as a moderator generally refer to cultural competence in an obscure manner. RCTs that are culturally adapted and minority-focused include cultural elements, making the role of the counselor and their cultural competence vague and unclear.

CHAPTER III

METHOD

This study utilized a qualitative methodology design. More specifically, a phenomenological approach was used. As defined by Creswell (2013), phenomenological studies aim to describe the common meaning among several individuals and their lived experiences of a certain concept of phenoma. The goal of phenomenological research is to compose a description of the essence of an experience. Using this methodological definition, this study explored the experiences of psychologists in their incorporation of cultural competence into interventions. Rationale for this methodology is found within its philosophical assumptions and the gaps in cultural competence literature. The following sections will discuss these assumptions and their relation to the topic of study.

III.1 Philosophical Assumptions

III.1.1 Implication of Methodology Paradigms

Lincoln and Guba (1985) describe paradigms as an extraction of what individuals think about the world but otherwise cannot prove. These paradigms are also deeply rooted in the socialization of the individuals who adhere to it. Thus, they stress that the actions taken by individuals such as scientists or inquirers do not occur without being situated in those paradigms. As a result paradigms have large impacts on how the world is viewed and understood. This manifests in how knowledge is gathered, interpreted, analyzed, and synthesized.

As such, there exist three paradigm eras through which knowledge has been acquired. The first, prepositivist era, was defined by a "passive observer" stance that many

individuals such as Aristotle took (Lincoln & Guba, 1985). Topics of logic and understanding nature from afar took precedence. When scientists began to become active researchers, this movement was slow. As it took force, it led into what is currently the dominant methodology, and the second era, positivism. Positivism asserts that what can be observed is objective and real. There is an assumption that objects that exist in space and time actually exist. Many of the natural sciences utilize this perspective, otherwise known as objective reality. However, critics of this paradigm claim that other than through an individual's own perception, it cannot be proved that the object is real and existing (Moustakas, 1994). Issues in this reality arise when questions being investigated involve mental and human phenomena or processes.

The third era, postpositivism, addresses the issues of reality when investigating topics related to mental and human phenomena. It recognizes that the data derived from natural science is not separate from theory. Data collected by positivist methods are considered to be based off a theoretical interpretation and not the facts themselves (Lincoln & Guba, 1985). Thus the data derived is laden with values, assumptions, and biases based on the theoretical interpretation. To shy away from this value-laden nature of data collection, the naturalistic or constructivist paradigm emerges from the postpositivist era. This study utilized the naturalistic paradigm in an effort to derive the meaning of cultural competence integration from facts. Cultural competence literature is wrought with inconsistencies and confusion regarding its application to practice. Exploring this phenomenon using experiential data can facilitate the comprehension of cultural competence integration currently used by practicing psychologists.

III.1.2 Assumptions of the Naturalistic/Constructivism Paradigm

To further understand how the use of the naturalistic paradigm is suitable for the exploration of cultural competence integration, it is pertinent to discuss its assumptions, or axioms. Lincoln and Guba (1985) have been forerunners in the explication of these axioms which provide a sound description of the naturalistic paradigm and its manifestation in research.

Axiom 1- The Nature of Reality

The naturalistic paradigm assumes the existence of multiple social realities. These realities can only be studied holistically and their inquiry will lead to more questions as the inquiry process continues. This axiom highlights the notion that research utilizing a naturalistic paradigm cannot predict or control outcomes. Rather it strives for a level of understanding.

Axiom 2- The Relationship of the Inquirer to Knowledge

This axiom posits that the individual inquiring about knowledge interacts with the person sharing the knowledge and vice versa. There is a dynamic relationship between the two and this must be recognized. This relationship cannot be separated or be considered mutually exclusive. Effects of this relationship can manifest within the research.

Axiom 3- Generalization

Unlike the positivist paradigm, the naturalist does not develop a generalization that can be held true anywhere and anytime. Rather, the goal of naturalistic inquiry is to create working hypotheses that can describe, in detail, the individual case. Thus generalizations from findings are not the goal of naturalistic design.

Axiom 4- Causality

Due to the dynamic nature between the inquirer and both knowledge and objects in existence, it is not possible to identify cause from effect. The continuous flux and shaping of entities makes causality impossible when utilizing a naturalistic approach.

Axiom 5- Role of Values in Naturalistic Inquiry

When knowledge is being sought out, it is always laden with values. Inquiry is influenced by 1) the person inquiring the knowledge 2) the choice of the paradigm used to seek knowledge 3) the choice of the theory that is utilized to guide data collection and analysis 4) the values that exist within context, and finally (5) the reinforcement or conflicting nature of values. Thus, values are inherent in research and impact various decisions.

III.2 Rationale

As discussed in the previous section, the goal of the naturalistic paradigm is to develop an understanding of a phenomenon with the use of rich description. Utilization of a naturalistic method of inquiry for the topic of cultural competence incorporation in psychotherapy allows for the exploration and comprehension of the phenomenon. The paradigm's focus on social and value influences on data allows for an understanding of how these factors may play into cultural competence integration. Given that the literature on cultural competence integration is cloudy, use of a naturalistic paradigm can shed light on and provide clarity to the experiences current practicing psychologists have with the integration of cultural competence into their therapeutic processes.

III.3 Participants

Purposive sampling was used as the sampling strategy for this study. This form of sampling was used to provide cases that were relevant to the research question, rich in

information, and would give in-depth knowledge so as to facilitate understanding of the phenomenon (Gavin, 2008). Use of purposive sampling yields non-probability samples. Non-probability samples are appropriate for qualitative methods because the aim of naturalistic inquiry is not to generalize but to come to an understanding of the phenomenon being studied (Marshall, 1996). In order to ensure detailed and rich data, homogenous samples were used in this study. Use of homogenous sampling allows for thorough investigation of a particular phenomenon within a specific context.

As a result of the research question and sampling strategy, participants for this study were required to meet several criteria. First, participants were to be current licensed and practicing clinical or counseling psychologists. Second, eligible participants' work load was to involve at least 50% direct client contact through psychotherapy. Third, participants must have had experience practicing in mental health settings with a diverse population and thus, have had some experience with encounters with racial, ethnic, and other minority individuals. Development of these criteria was based upon the research question- use of cultural competence in interventions. Utilizing these criteria ensured that participants had experience in and could provide information about the phenomena being studied. Total number of participants included eight psychologists.

III.4 Recruitment

Participant recruitment involved the "snowball" strategy. The snowball method utilizes current participants to recruit and contact future participants who may fit the study criteria (Eide, 2008). Use of this method ensured that the participant had met the previously described criteria. Participants were recruited through contact with local professional psychological organizations, a psychology staff meeting at the Central Texas

Veterans Health Care System (CTVHCS), and professional contacts of the researcher and principal investigator (PI) of this study. The following local professional organizations were contacted to obtain permission to send an electronic flyer (Appendix A) through email listservs: Brazos Valley Psychological Association, Fort Worth Area Psychological Association, Houston Psychological Association, Bexar County Psychological Association, and Capital Area Psychological Association. Capital Area Psychological Association did not allow non-members to send email through their listserv. Thus, no participants could be recruited from this organization. Within the CTVHCS the researcher provided email and printed copies of the electronic flyers to a staff psychologist who disseminated the information at a monthly psychology staff meeting. The electronic flyers sent to the local professional organizations and disseminated at the CTVHCS psychology staff meeting provided information about the study, why it was being conducted, who was conducting the study, and the researcher and PI's contact information, The flyer also informed participants of the criteria they were required to meet if they wished to volunteer for, the method (in-person or Skype video conferencing) and estimated one to two hour length of the interview, the requirement for audio recording of the interview, validation of the transcribed responses, and details about compensation ($50 VISA gift card). In addition, the flyer informed participants who wished to volunteer through Skype video conferencing, that a preferred mailing address would be requested to send compensation. Interested participants were asked to contact the researcher through email or phone.

Participants who were contacted through the professional contacts of the researcher and PI were sent the same electronic flyer through email and were requested to pass the information onto other individuals they may be aware of and fit the criteria. The

professional contacts were also informed that if they were interested in volunteering for the study they could email or call the researcher.

Participants who contacted the researcher and expressed interest in volunteering were sent a second email with further detailed information about the study including privacy and confidentiality (Appendix B) as well as a copy of the consent form (Appendix C). If participants still expressed interest in volunteering at this point, a date to meet in-person or interview over Skype video conferencing was scheduled. For interviews that occurred in-person participants were given a paper copy of the consent materials that included study details on the day of the interview and were provided time to discuss any questions or concerns prior to signing. For interviews that occurred over Skype video conferencing the consent materials were provided to the participant through email prior to the start of the interview. They were then requested to sign, scan, and email the consent form to the researcher before beginning the interview. For both in-person and Skype video conference interviews, once the consent form was received and signed, and any questions or comments were addressed, participants were notified when the audio device recording was turned on and the interview would began. Upon completing the interview participants were compensated for their time with a $50 Visa gift card. For those participants who interviewed through Skype video conferencing, the gift card was mailed to the preferred mailing address provided.

A total of 11 participants were in contact with this researcher. Of these participants three were not interviewed due to email response or scheduling issues. Two of the three participants did not respond to the second email sent with further detailed study information and consent form. The researcher sent two follow-up emails to both of these

participants. In the second email the researcher indicated that if the participant still wished to volunteer they could email or call the researcher. For the third participant that was not interviewed, a common meeting time with the researcher was not able to be identified due to schedule conflicts.

The remaining eight participants were interviewed by the researcher. Three of these interviews were conducted through Skype video conference. Of the eight participants who were interviewed three had no relationship to the researcher. However, of these three participants two had professional relationships with the PI. The remaining five participants had some form of relationship with the researcher. One participant in the study overall had no relationship with either the researcher or PI.

III.5 Data Collection

Data collection occurred using a semi-structured interview protocol. Semi-structured interviews allows for direct questions to be asked to the participant while simultaneously giving them, and the researcher, freedom to address topics and issues that are not outlined in the protocol (Hugh-Jones & Gibson, 2012). Use of semi-structured interviews for this study allowed for the researcher to ask questions pertaining to the phenomenon being studied while also providing space for the participant to discuss other topics that may not have been anticipated.

Questions in the protocol were developed utilizing the knowledge, skills, and awareness of cultural competence as outlined in Sue et. al.'s (1992) Tripartite Model of Cultural Competence. Rationale for the utilization of this model as the developmental foundation of the protocol is twofold. First, its consistent use across disciplines such as psychology, nursing, medicine, and social work emphasizes its wide applicability and

provides a foundation from which clinically-focused questions can be developed. Second many of Sue et. al's (1982) and Sue, Arredondo, and McDavis' (1992) Tripartite Model ideas have influenced conceptualizations of culturally adapted mental health treatments (Bernal, Jimenéz-Chafey, & Rodríguez, 2009).

Additional questions were developed by the researcher to collect data that may not fit within the theoretical confines of the Tripartite Model. These questions were developed to a) gather information describing the variation in their work schedule, b) capture broad ideas of culture as conceptualized by the participant, c) gather data of professional challenges and strengths as related to cultural integration in psychotherapy, and d) gather data about the perceived improvements needed within the mental health care field to address cultural competence. The interview protocol that was used is shown below. Questions were asked in the same order to all participants.

1. Can you describe a typical working day?
2. Broadly speaking, what are your views on culture in mental health care?
3. How would you describe your approach or stance to culture in your clinical work?
4. What does being a culturally competent psychologist mean to you?
5. What are your thoughts about the knowledge required to work with culturally diverse clients?
6. How do you incorporate culture in the establishment of a therapeutic alliance?
7. How do you gather cultural data from your clients?

8. Once cultural data is gathered from your clients, how do you use what you have to conceptualize the client?
9. How do you use cultural considerations in assessment and diagnosis?
10. How do you draw on culture to inform goal setting and treatment planning?
11. In what ways do you use cultural data gathered to inform and select treatment interventions?
12. How do you use culture to evaluate therapeutic outcomes?
13. What have been some of your challenges in working with culturally diverse clients?
14. What do you feel the mental health field could do better in terms of providing you the means to be culturally competent?
15. What have been some of your strengths in working with culturally diverse clients?

Data collection also involved use of probes to follow-up with issues raised in the interview, encourage elaboration, and clarify statements (Gavin, 2008). Use of probes ensured that the information being provided was detailed and rich in its nature as well as accurate and correctly comprehended. Examples of probes that were used during the interview process include:

1. Can you tell me more?
2. Can you give me an example?
3. So what you are saying is…. (summary of participants' response). Am I understanding you correctly?

Data collected also included codes to identify non-verbal data. The following codes had been developed prior to the start of the study as anticipatory:

1.Long pause: LP

2.Hesitation: HST

3.Non-direct eye contact: NDEC

4.Pacing: PCG

5.Restlessness/Fidgety: RSTL

6.Body posture relaxed: BPRL

7.Body posture tense: BPTN

Given the assumptions of the naturalistic paradigm that data cannot be predicted and that data is in constant flux due to dynamics between the researcher and participant, it is not uncommon to see the addition of observational data other than those hypothesized prior to the start of the study. However, in this study, additional non-verbal data codes were not developed as the codes that were created as anticipatory accounted for all non-verbal data observed by this researcher. However, other types of observational data were collected by the researcher about the interview setting/location, encounters between researcher and organization staff, relationship between the researcher and participant, and any other relevant information that may have impacted the questions being asked and the answers provided. These observations were recorded in a reflexive journal that was strictly used for observational, methodological, and analysis purposes. Use of this journal in the study is discussed in the data analysis section.

Interviews were recorded using a digital audio recorder. The recorded data was stored on a USB drive in a double locked room. Once each interview was completed and

recorded, verbatim transcriptions of the data were typed. Transcribed data were saved on a separate USB drive within a password protected file. These verbatim transcripts were sent to the corresponding participants for member checks. The researcher requested the participant to read the transcript and ensure that all ideas and content were accurately captures.

III.6 Data Analysis

Lincoln and Guba (1985) state naturalistic inquiry to be inductive, generative, and constructive in nature. Inductive analysis refers to the development of constructions from data, independent from theory. Generative analysis involves the discovering of constructs using data as a starting point. The constructs developed using this analytic method may lead to hypotheses. Constructive analysis refers to a process of abstracting units from behavior. To facilitate these forms of analysis, field notes, reflective journals, and codes of the verbal data using typed transcriptions were used. Each of these three methods served an important part in the final interpretation of data. Further descriptions of these methods are discussed below.

III.6.1 Field Notes

Field notes were used during interviews to record observations of the participants, location of interview, relationship dynamic, and any reactions, by the researcher or interviewee, to the material discussed. The field notes also included the non-verbal codes discussed in the data collection section. Observations made in the field notes will be further discussed in the results section of this paper.

III.6.2 Reflexive Journal

A reflexive journal was maintained throughout the duration of this study to log day-to-day activities, reflective and introspective notes, and methodological logs. Reflective and introspective notes described thoughts occurring in relation to the study, personal biases that may have influenced perception of the data, expectations of the study, hypotheses, questions to follow-up or discuss with the participant, and a section to express any frustrations or concerns. The methodological logs also included all methodological decisions and changes made during the study. Notes made in the reflexive journal will be expanded on within the results section of this paper.

III.6.3 Data Coding

Coding of data utilized a modified content analysis hybrid with Glaser's **(**1967**)** constant comparison approach. Content analysis refers to a process of naturalistic data analysis in which text are divided into units of meaning (Lincoln & Guba, 1985). Through content analysis data are generally reduced and made sense of (Julien, 2008). In its truest form content analysis is completed within the realms of its five major characteristics. The first being that the process is carried out with explicitly formulated rules and procedures. Second, content analysis is a systematic process such that the inclusion of exclusion or content is done in accordance to consistent rules. Third, it aims for generality. Fourth, the process deals with manifest content. And lastly, content analysis is viewed as a quantitative technique (Lincoln & Guba, 1985). As structured as these characteristics are, Lincoln and Guba (1985) propose that naturalistic data coding should be guided but not constrained by the conventional content analysis method. In particular, Lincoln and Guba (1985) discuss modifications that can be applied to content analysis within naturalistic inquiry. These

modifications state that 1)rules do not need to be finally formulated till the end of the inquiry; 2) the systematicity requirement of this process can still be achieved under ex post facto rule development given that all data has been processed according to the same rules; 3) the aims for generality as a requirement are rejected; 4) context and latent data, not only manifest data, are important to meaning making and; 5) the frequency with which themes or categories appear does not have to relate to its importance, thus content analysis is not necessarily quantitative in nature.

The purpose of the constant comparative method is to generate a theory or understanding that comes from and is close to the data gathered (Glaser, 1965). Although the constant comparative method was developed to derive theory, the data processing method used is beneficial for naturalistic inquiry and provides sound structure from which to analyze data. This method consists of four stages. Each stage is further described below.

Step One- Comparing Incidents Applicable to Each Category

This step involves coding each incident, or unit. A unit is defined as being heuristic, such that it aids in the understanding of a phenomenon. A unit must also be the smallest piece of information that can stand by itself and be interpretable without the context in which the data collection (interview) is carried on (Lincoln & Guba, 1985). During this stage of data coding each unit was compared with the previous units in the same and different groups. This allowed for the development of category properties and descriptions. Once coding occurred for a category three to four times, memos on the ideas generated from the data on the ideas generated from the data were written. Glaser

(1965) and Lincoln and Guba (1985) propose writing a memo which aids in the retention of the immediate thoughts of the inquirer regarding theoretical notions.

Step Two- Integrating Categories and Their Properties

This stage in data analysis involved changing the comparative process from units with units to units with category properties that were derived in the first step. Identifying properties of categories facilitates the integration of categories making each category unified and whole. The identification of properties and integration of categories begins to take the form of an explanatory construction (Lincoln & Guba, 1985).

Step Three- Delimiting the Theory

This step in the constant comparison process is generally conducted to develop a theory. However, theory development was not the aim of this study. Rather, this study aimed to describe the phenomena of cultural integration within psychotherapy. Additionally, delimiting a theory requires a much larger sample. The participant sample size of this study is not sufficient to engage in theory development. Therefore, step three in this process was skipped.

Step Four- Writing the Construction

At this stage once data coding and memos were completed, the descriptions of the content of each category began by developing the written construct. It is at this stage that the description of phenomena of cultural data integration into psychotherapy was completed utilizing the units and categories derived from the constant comparison and content analysis approaches described above.

CHAPTER IV

RESULTS

This study explored how psychologists incorporate cultural data into their overall psychotherapy practice. Though much research has been conducted on cultural competence there remains a lack of agreement on its definition and components (Huey, Tilley, Jones, & Smith, 2014). As a result, none of the three major models of cultural competence have been demonstrated to contribute to therapeutic outcomes. This study aimed to shed light on the components and the method by which cultural competence contributes to therapeutic outcomes by exploring the use of culture in psychotherapy by psychologists.

This section presents findings that evolved from data collected from interviewing eight licensed and practicing psychologists. The interview protocol utilized questions that would allow for thick and rich descriptions of the participants' use of culture in all the stages of psychotherapy, including broad questions addressing their thoughts about culture in mental health, the challenges they have faced, and the strengths they possess working with diverse clients. Analysis of the transcriptions of the interviews resulted in patterns of thought that were coded into individual units of meaning. These were identified by comparing units with units. The next step of analysis involved comparing units with categories to identify the properties and characteristics of each category. This allowed for the construction of an explanatory description of the phenomenological experience. The properties of these categories were refined till a cohesive description ready to be written was produced.

IV.1 Summary of Participants

Results of this study were developed through data collected by interviewing eight participants. The participant criterion previously described allowed for recruitment of participants that would more likely than not have the experience of the phenomena being studied - incorporation of cultural data in psychotherapy. Detailed descriptive data for each participant can be found in Table 1. As can be seen in the table, the majority of participants in the study were female and white with 50% having had training in clinical psychology and 50% in counseling psychology.

It is important to note the range in years of practice since licensure. One participant, P5, had only passed her licensure exam one week prior to this interview. Reasoning for her inclusion in this study stems from the nature of clinical training in psychology doctoral programs. For an individual to obtain licensure as a psychologist, a minimum of four years of graduate work, one full year of a clinical internship, and one year of post-doctoral supervised clinical work must be completed. Additionally, during the four years of graduate work, psychology doctoral students are continuously engaged in various clinical experiences through multiple practica. These requirements ensure that freshly licensed psychologists have had a minimum of six years of clinical experience. Additionally, due to the increased awareness and research on the impact of multicultural factors on mental health and well-being, the American Psychological Association (APA) released a set of guidelines in 2002 on multicultural education, training, research, practice and organizational change for psychologists. Recently, APA released an updated version of these guidelines indicating that psychology programs should include multicultural

curriculum and be able to provide clinical and supervisory experiences within diverse environments (APA, 2017). The development and revisions of these guidelines indicate that current psychology graduate programs have more intensive training in multicultural factors of psychological well-being than programs of the past. This suggests that recent psychology doctoral graduates may be more inclined to consider cultural factors in treatment than their counterparts who graduated and obtained licensure prior to the release of the 2002 APA multicultural guidelines. It is for this reason that P5 was allowed to participate in this study. Further descriptions about the participants, their clinical activities and observations made during interviews are shown in Table 2.

Table 1

Descriptive Data of Study Participants

Participant Code	Gender	Identified Race / Ethnicity	Practice Setting	Time in Practice Since Licensure	Training Type
P1	Female	White	Private practice		Clinical Ph.D.
P2	Female	White	Private practice	6 years	Clinical Ph.D.
P3	Female	Asian	College counseling; part-time private practice	24 years	Counseling Ph.D.
P4	Female	South Asian	Private practice - two locations (suburban and urban)	15 years	Clinical Psy.D
P5	Female	White	VA specialty clinic (PTSD Clinical Team-PCT)	1 week	Counseling Ph.D.
P6	Female	Hispanic	College counseling	9 months	Counseling Ph.D.
P7	Male	White	Private practice; also part-time professor at community college)	12 years	Counseling Ph.D.
P8	Female	White	VA specialty clinic (Primary Care Behavioral Health-PCBH)	7 years	Clinical Ph.D.

Table 2

Participant Summaries

Participant Code	Clinical Activities	Method of Interview	Non-Verbal Observations	Relationship Dynamic Observations	Environment/Setting Observations
P1	Individual clients (adults and family 6-8/day); notes/documentation; 50-60 minutes sessions	In-person	BPRL, LP	Engaged; showed interest in questions being asked and the study being conducted	Interview occurred in participant's office during lunch hour; participant was eating; participant had allotted two hours for the interview
P2	Session preparation; review of treatment plans; case conceptualization; individual clients (adults 5-6 /day); return emails; notes/documentation; forensic practice-legal assessments and evaluations 1 day/week	In-person	BPRL, LP	Engaged; dynamic with participant felt comfortable to the researcher due to previous relationship	Interview occurred after participant's work hours; participant was eating
P3	24 client hours/week (college students and adults); individual sessions; crisis interventions; group therapy; consultation; notes/documentation; part-time private practice	In-person	BPRL, LP,HST	Engaged; eager to answer questions; showed several empirical articles related to cultural competence to the researcher	Interview occurred in participant's office during working hours
P4	Individuals clients (mix of adults, adolescents, and families with children); notes/documentation	In-person	BPRL	Engaged; participant appeared to be more formal in her responses when compared to other participants	Interview occurred in participant's office during work hours
P5	Individual clients (adults, combat Veterans); group therapy; under supervision for specific evidence based treatments (EBTs); consultation; notes/documentation	In-person	BPRL	Engaged; brief and precise responses	Interview occurred in a coffee shop preferred by participant
P6	Individual clients (2-5/day); group therapy; staff meetings; provide supervision	Skype video conference	BPRL, NDEC	Brief and precise responses; interview appeared to be rushed	Participant was at home during time of interview on a weekend; had head to waist view of participant on screen
P7	Teaching at community college; individual clients at private practice (adults and adolescents 6/day)	Skype video conference	BPRL	Engaged; participant appeared to be comfortable discussing his challenges in psychotherapy	Participant was in his office at the community college; had head to waist view of participant on screen
P8	Individual clients seen in 30-minute or less sessions (2-3 scheduled/day, varied rate of unscheduled clients); group therapy; brief consultation with new clients; communication with nursing staff and physicians to coordinate care	Skype video conference	BPRL	Engaged; comfortable dynamic with participant	Participant was at home during time of interview on a weekend; her young child could be seen and heard talking in the background, child spoke to the researcher once; had head to knees view of participant on screen

IV.2 Standpoint Epistemology

Before the themes of the study are discussed in detail, it is important to address this researcher's cultural and social frame as it relates to the data gathered and interpreted. Standpoint theory offers theoretical grounds for the inclusion of this reflection. Standpoint theory asserts that any society stratified by cultural factors such as race, ethnicity, gender, sexuality, etc. has individuals at the top whose actions organize and set limits on what other individuals performing these actions can understand about themselves or the world around them. In other words, the social context in which an individual is situated within enables and sets limits on what one knows. Standpoint epistemology adds to this concept by recognizing the relationship between knowledge and "politics" and the impacts this has on the production of knowledge (Harding, 1992). Within phenomenological research, the researcher collecting data can be viewed as the individual at the top performing certain actions. His or her social context modulates and limits the type and amount of knowledge that is produced. Within phenomenological research, the researcher is often the instrument by which data is gathered, analyzed and interpreted. Consequently, phenomenological research requires the researcher to be intimately involved with the data and its interpretation. Thus, it is important to consider how my social context as the researcher may have colored the knowledge produced within this study. My standpoint epistemology may have impacted the method of data collection, its interpretation, and its use in the development of categories within this study. For this reason, I have described here my social context and how it has impacted my views on culture and psychotherapy.

I am a South Asian female born in India and immigrated to the United States at the age of two. As an immigrant I have consistently been surrounded by the recognition of

cultural differences. I am currently working towards a doctoral degree in counseling psychology studying cultural competence. I have spent approximately 10 years, spanning from my undergraduate to doctoral education, studying culture in psychology programs. My research interests have primarily revolved around the impacts of culture on mental health and broad health disparities. These interests have led me to be the team lead for a research team conducting studies focused on multicultural competence. I held this position while simultaneously developing the proposal for this dissertation study. During my time as research team lead I was immersed within cultural competence literature for a full year. My role within this team involved collaborative development of a model addressing cultural competence in psychotherapy, conducting model critiques, developing manuscripts, and participating in related conferences. Additionally, my clinical interests also involve working with culturally diverse clients and I have sought out these individuals when available. As a result of these experiences, I view myself as an individual that is highly sensitive to cultural factors both in my professional and personal life. Adding to this narrative, my most recent transition was a move from the urban city of Chicago to a location in the Southwest that has had much more of a homogenous population. This move alerted me to the differences in lifestyle and values espoused by the populations that inhabit these two locations. Experiencing this shift in values within my environment has, in my perspective, increased my sensitivity to culture.

IV.3 Emerging Themes

Results from the data initially produced eight themes. These themes were documented in a memo to gather the researcher's initial thoughts and explanations of the

data. Upon further analysis of the transcriptions, the eight initial themes were organized into two categories, one of which included two subcategories and four subsets of one subcategory. At this time, the data showed the addition of a third category which included three subcategories. The following section will describe each category using excerpts from the transcriptions to help further describe the participants' experiences.

IV.3.1 Category One- The Nature of Cultural Competence

The interview protocol included questions that gathered information on the participants' use of cultural data in all stages of psychotherapy. In addition, broad questions addressing general thoughts about culture in mental health were also included. As a result, the data showed an emergence of the nature of cultural competence, its components as described by the participants, and how it is conceptualized within psychotherapy. A total of five out of eight participants described cultural competence as fluid, ongoing, and process-oriented. It is this continuous process-oriented nature that participants described as the essence of utilizing cultural competence in psychotherapy. Relatedly, in its truest form, cultural competence was a phenomenon that three out of eight participants described as something that can never be fully achieved. This is to say that cultural competence requires continuous learning, thought, and adaptation through the therapy process. Participant 8's (P8) comment about her thoughts of what being a culturally competent psychologist means to her highlights its continuous, on-going, and fluid characteristics:

> "*Like I kind of feel like, again, there's no checkbox that you can tick off that says now I'm competent. But, but, I think being willing to keep approaching new material, learning new things for my patients, or from my colleagues, in the*

literature, that means competence to me. Just like any other piece of what we do, like I wouldn't check off a box that says you know, clinically competent, and then never keep learning."

Another example of this continuous process is described in Participant 4's (P4) statement to the same question of what being a culturally competent psychologist means to her:

"And it takes a lot of background for us as mental health professionals. It takes us to understand, study further about okay, if someone is coming from a Latin American culture I have to actually, you know, do some background study about how these people are, how they present themselves, and uh, you know kind of keep checking in with them constantly about is it okay?"

IV.3.1.1 Subcategory One- A Willingness to Learn

Common within these responses was the conceptualization of cultural competence as involving a key component; a genuine willingness to learn. This component permeated throughout all eight participants' interviews and as such was deemed a critical subcategory that defined an attitude that was necessary for cultural competence. Participants' responses went on to further describe this attitude as a guide to methods of thinking and behaving that facilitated them towards cultural competence. The thinking or cognitive aspects of this subcategory could be described as an awareness that understanding a client's cultural background and experience requires active learning and adaptation of one's thoughts. The behavioral components of this subcategory refer to the action of seeking out this information whether it is through inquiring the client or gathering culturally relevant data through other academic means such as workshops, conferences, or research. Given that cultural competence was described as a continuous process and a phenomenon that could

never fully be achieved in its truest form, a willingness to learn was also seen as on-going. This attitude was described as being necessary due to recognition that one cannot be competent in all cultures and identities. This idea can be seen in Participant 1's (P1) statement when asked about her thoughts on the knowledge that is required to work with culturally diverse individuals:

> *"I don't think it's ever something I can be an expert in. So I always think there's more to learn, to try to understand."*

Underlying this subcategory, participants also described a latent intention to seek out culturally relevant knowledge. Thus, a willingness to learn not only included openness to new information but an actual objective or goal to seek this information and develop their cultural competency. An excerpt from Participant 3's (P3) interview captured this description:

> *"Part of what I talk about is that there's not a lot of in-depth curriculum on a lot of the cultural issues and background and so forth for specific populations. So, even though they are not there in the curriculum, then if you are interested in learning about it you have to seek out those opportunities. And either provide yourself the workshops, you know attending seminars, readings and so forth. And so the intention is that really including, I mean increasing your cultural competence. That is a life long journey. So you have to be intentional about what you learn."*

Another excerpt from Participant 6's (P6) interview highlights the attitude of being willing to learn as well as an intention to seek out culturally relevant knowledge because it may not be possible to be competent all cultures:

"I think it requires a lot of knowledge. Um, not necessarily knowledge about different cultures. I do think you should know about some cultures but if you're working with a client who you don't know a lot about their cultural background, it's important to do your own research."

IV.3.1.2 Subcategory Two-A - Knowing What You Do Not Know

The second subcategory that defined that nature of cultural competence in psychotherapy was differentiated into Subcategory Two-A and Subcategory Two-B. Subcategory Two-A encompassed the idea of knowing what you do not know. This was a theme that emerged in all eight participants' interviews. Participants described this theme as the awareness of one's own gaps in knowledge about the client's culture or the client themselves as a necessary component to facilitate cultural competence. This subcategory is a bridge from the Category One's description that emphasizes the notion of cultural competence can never fully being achieved. That is, if psychologists are to work towards the attainment of cultural competence, and the inherent nature of cultural competence is such that it can never truly be achieved, then knowing what one does not know about a client's cultural group or identity is a critical component. Thus, participants described that by possessing awareness of the gaps in one's own cultural knowledge it provides an opportunity to intentionally open oneself to learning and gathering more culturally relevant information. The response below by Participant 5 (P5) provides an example of this:

"However I do think that um, a competency that should be there is knowing what you don't know. Um, and knowing what you bring to the table and how that impacts your work. And so really, sort of confronting your own stuff or whatever that may be and however that may impact the um, therapeutic rapport."

An excerpt from Participant 2's (P2) interview also sheds light on the awareness of what one does not know and its necessity for being culturally competent:

"The part of being competent is being willing to learn, so asking questions and not being afraid to ask questions (about) the things you don't know about."

IV.3.1.3 Subcategory Two-B- Not Knowing What You Do Not Know

Related to the properties in the previously described subcategory, the new Subcategory Two-B described the notion of not knowing what one does not know. This subcategory broadly defined the concept that a psychologist cannot be expected to know all that there is to know about all cultures. One participant, P8, explicitly discussed this in her interview when discussing her strengths in working with culturally diverse individuals:

"But just to be willing to be human, not knowing everything, willing to learn from this person sitting across from me."

Given that cultural competence was described as on-going process requiring an attitude of continued willingness to learn as well as an intention to learn about culturally relevant data, this subcategory also highlighted a latent recognition among participants that a psychologist realistically cannot be aware of all the nuances of every cultural group in existence. It is for this reason that cultural competence must be continuous and that one must always be willing to learn. An excerpt from Participant 7 (P7) also discussed his awareness that a psychologist cannot know about every culture:

"I mean, I don't know if that's even achievable, you know? Um, I mean I understand my culture somewhat, not even entirely, you know? Much less, understand everybody else's culture that walks into my office. Um, so you know, where we've improved on that is we've kind of, you know, gotten away from that

kind of idea that we have to be culturally competent in every culture that comes in our front door. So people have kind of backed off of that viewpoint and say, you know, what we have to do is we have to be respectful of each other."

Within this excerpt P7 also discussed his awareness of a shift in the mental health field from the expectation that psychologists must know everything about cultures that they meet in order to be culturally competent, to one that is more focused on respecting differences of an individual regardless their cultural background.

In addition, four participants described ways in which a lack of knowledge of what is unknown to the clinician could influence treatment. One was by the unknown unique cultural and individual characteristics of the client. Participants described that simply knowing the cultural background of a client does not preclude them from misattributing certain cultural factors onto the client. Rather participants described what is needed is an awareness of what unique cultural and individual factors that the psychologist does not know of and can later gather more information on. This reduces the possibility of assuming and misattribution of cultural factors. An excerpt from Participant 4's (P4) interview provides a good example of conducting one's own research about a client's cultural background but also taking the time to periodically assess if the researched cultural data are relevant to the client and are not being misattributed:

"Okay, if someone is coming from a Latin American culture, I have to actually you know do some background study about how these people are, how they present themselves and uh, you know, kind of keep checking in with them constantly about, is it okay? Just be more sensitive to the culture, the person."

The second manner in which not knowing what you do not know can impact treatment is through the aspects of self such as personal experiences, values, biases, and judgements that may be interacting with the client and their treatment. P1 describes her reflections on a specific experience with a Hispanic client and how awareness of her values and opinions can impact the course of treatment for culturally diverse clients:

> *"I need to be aware, cognizant of and respectful of cultural values and beliefs that I don't, um, portray. So for, a patriarch of a Hispanic family that comes in, he may not, or,I may find in working with a couple he's not going to listen to anything I say. And you know, I'm usually pretty good with people. But, you know, I have to be mindful of the fact that it may be a cultural thing. I don't think I take it personally, but I also need to respect that. Can he believe that I can be helpful? And I'll ask. And if he doesn't think so, I will very very willingly talk to them. Well let's see if we can find someone who can. Because, it's possible he's willing to see a woman if they can speak Spanish."*

The data also showed an emergence of subsets in this subcategory. These subsets further define and describe the idea of knowing what you do not know and provide details on what skills and techniques the participants use to facilitate cultural competence in their practice.

IV. 3.1.3.1 Subset one- asking the client. This subset describes a theme that emerged within seven out of eight of the participants' interview data. Participants described asking the client as a method to make the unknown known. That is, it allows for psychologists to gather the unique cultural and individual data from the client's perspective. In doing so, participants described that this created a space for discussion

about cultural factors that may be playing a role in the client's psychological presentation. Additionally, asking the client asserts the client as the expert on their culture and individuality. Participants described that this placement of the title of expert allowed for clients to feel more comfortable to discuss any cultural factors. An excerpt from P2's interview where she describes her experience of working with a Black woman is provided below as an example for this subset:

> *"Because even if you find generalized knowledge from research, applying it idiographically may not be okay. So her experience may not be the same as the generalized norm from the research. You know what I'm saying? So I think it's better to you know, yeah read that stuff but then ask the person what they come with, and get to know that person's culture. Because, just because they're Black for example, doesn't mean that everything we know about Black culture applies to them."*

In this excerpt the participant emphasizes the importance of gathering the idiographic cultural data of clients even if one has a general knowledge and understanding of the culture. She states that by using only generalized knowledge one bears the danger of assuming the client's experiences incorrectly. By asking the client about her personal experiences of being a Black woman, P4 recognizes that there may be information about the client's individual cultural experience and larger Black culture that she may be unaware of that could be impacting the client's concerns.

IV.3.1.3.2 Subset two- no assumption. The theme of not assuming aspects about the client's cultural experiences emerged in seven out of eight interviews. Participants described this as one of the key features in developing cultural competence that is

accomplished by asking the client about their cultural experiences. Participants described the idea of not assuming to pay homage to the notion that each client enters psychotherapy with individual experiences and stories that may not fit a specific generalized cultural narrative. Thus, for a psychologist to progress towards cultural competence, a clinician cannot make assumptions based on these generalized cultural narratives as these may not fit within the client's experiences. One participant, P2, shared her experience of failure when only using previously acquired knowledge about a cultural group without conferring with the client:

> *"The times that I have been the most effective have not been, oh yeah I learned that in graduate school, or oh yeah I just read an article about that. Oh and I know, I know what you mean, I know what you're coming in with. Those are the times that I have failed very, very, very bad".*

In an example from P6, she defines and describes the importance of not assuming client cultural characteristics which she describes as flexibility in thinking, She goes on to state how this flexibility in thinking allows for the client to describe their personal narrative. In this specific excerpt, P6 was asked to elaborate on her meaning of flexibility in thinking:

> *"The possibility of ways of thinking in the therapist. So uh, not necessarily having a one size-fits-all in terms of the broader cultural categories. Um, and I think that flexibility would encourage therapists or psychologists to ask open-ended questions where the client gets to describe their own experience."*

IV.3.1.3.3 Subset three- cultural data gathered at intake and throughout the therapeutic process. This subset described the process by which cultural data are gathered. Although the exact means by which cultural data were gathered varied depending

on the location of practice (e.g. private practice or VA), all eight participants described cultural data as often gathered during the intake process by use of forms developed for their practice as well as an initial clinical interview. Participant 8, however, did not report the use of an intake form and described her process as "direct inquiry." She indicated due to her work in a specialty clinic with limited 30-minute sessions she would often have to gather data by directly asking her clients about their cultural data. Examples of cultural data gathered on intake forms and clinical interviews include self-identified race, gender, and sexual orientation, place of birth, religion, family structure, and education. Participants also described that gathering cultural data is, much like cultural competence, a process that continues and evolves over time. Participants described gathering cultural data as unfolding over time as the therapeutic relationship developed and strengthened. All eight participants indicated that while information gathered in intake forms or initial clinical interviews were certainly important and helpful, it was also understood that many other cultural data points would surface as the therapeutic alliance strengthened over time and the client became more comfortable. It was also indicated that intake forms and clinical interviews only "scratch the surface." An excerpt from P5 describes the surface-like characteristic of intake forms:

> *"So I just said I don't take just what's on the surface but that's where you start, usually. I think that the intake packets that we have in our clinic um, are relatively helpful. Um, but then they can only go so far. And usually it asks questions on how they self-identify, um, race, religion sort of spiritual concerns, background concerns, gender identity issues, sexual orientation, things like that. And so that's a nice starting place if they mark it, which they usually don't. Um, and so just having*

a conversation when I'm doing the intake about where um, you know their concerns come from and how their family handles things like that."

In another example, P4 describes how she uses the initial cultural data gathered as a foundation to start developing a treatment plan:

"So you know, yeah, that's the basis. That's your foundation where you start ,you know, forming some sort of concept about how to approach this person based upon their family story, their family dynamics."

This fluid nature of data collection also appeared to inform the case conceptualization process. Participant 5 labeled case conceptualizations it as "a living breathing thing" indicating that it changes as new cultural data is gathered, synthesized and interpreted over the course of the therapeutic relationship.

IV.3.1.3.4 Subset four- in-depth knowledge from interaction and experiences.

Knowledge was described by participants as best gathered through interaction with members of a cultural community or group of interest than through traditional textbooks. Data shows that while traditional "textbook knowledge" is important and serves as a good starting point it does not provide the depth of knowledge that is often required to work with culturally diverse clients. In addition, participants described knowledge gathered through traditional means (such as textbooks) as having a risk of stereotyping a cultural group. P7's discussion about the knowledge of cultural data highlights this theme:

"Well I think there has to be at least some knowledge base there. Um, so I mean we have coursework and required continuing education and, and that sort of thing. Um, I personally have not found most of that to be very helpful. Um, I see your colleague as having done the best job of anybody I've seen to bring workshops to

probably have more meaning behind it. So, and the reason why I say that is because as soon as you say okay, the Hispanic culture looks at things this way then you have done the same thing you're trying to get people not to do, which is stereotype and use a different criteria."

Rather than acquiring knowledge through more traditional means, participants described that knowledge of culture requires development through; 1) interaction with clients and asking their perspective of the cultural experience as related to their psychological concerns; 2) involving oneself in immersive projects or experiences such as talking to members of a cultural community/group of interest or attending culturally related events in one's local area; 3) intentionally seeking out workshops, continuing education credits (CEUs), and other programs geared towards multicultural topics and; 4) engaging in self-directed research by reading books, articles, journals, and conducting "cultural background studies." As described by P4, a cultural background study entails review of the literature regarding a client's cultural background assessing various aspects of the culture such as familial roles, sociopolitical issues, and family dynamics. Although the field has not adopted the use of the term "cultural background study", based on the description provided by P4, its closest synonym would appear to be the knowledge component of Sue's (1992) Tripartite Model of Cultural Competence. Sue specifically addresses the types of knowledge that facilitate multicultural competence. These include knowledge of racial identity development, impact of race/ethnicity on personality development, career choices, and psychological diagnoses, the effects of institutional barriers, and any current discriminatory practices (Sue, 2001). Based on this description, it is likely the term cultural background study espouses similar concepts discussed in the

knowledge component of the Tripartite Model but with a widened scope addressing cultural factors outside of race and ethnicity.

IV.3.2 Category Two- Responsibility of Therapist

This category describes a sentiment that was prevalent in four out of eight participants' interviews. It defined the role and responsibility of psychologists to initiate the discussion of culture in session. The participants' descriptions indicated that it is not uncommon for clients to at times be afraid or unsure about discussing cultural factors or to be unaware of which of their own cultural factors may be playing a role in their psychological presentation. In addition, due to the inherent power differential between psychologist and client, participants described the clinician as having the responsibility to open the floor for discussion about relevant cultural factors in session. Participants also stated that having this responsibility helps to facilitate the idea of a "safe space" in which the client's culture could be discussed without judgment.

The participants' description of initiating the discussion of culture in session falls in line with Day-Vines, et. al.'s (2007) concept of broaching. Broaching is described as a clinician's ability to recognize cultural factors related to the client's presenting concerns and translate this knowledge into meaningful practice. Day-Vines et. al. (2007) provide several arguments for the inclusion of broaching in psychotherapy. These include increased perception of clinician credibility and competency, greater depth of client disclosure, and strengthened therapeutic alliance through the fostering of intimacy allowing the client to become empowered.

The methods in which participants introduced culture in session appeared to vary. However, most fell within two categories: 1) identifying and verbalizing cultural

differences between the psychologist and client and asking how, if at all, it may impact treatment for the client or; 2) direct inquiry about the client's various cultural factors such as preferred pronoun, place of birth, family origin, etc. P1 provided an example of her method of identifying and verbalizing cultural differences between herself and a client of Muslim background:

> *"I had one client a few years ago. I asked her if she had ever considered trying to see a psychologist or counselor who was Muslim because we have one. Um, and she said that she didn't, she didn't think that it was necessary. So we talked about that. Why she felt she was comfortable and could be helped by me and so, I don't try to get rid of them. I mean I don't try to move on but I like them to know that I'm aware that if it's an issue or concern to please talk to me about it. Let me know if I'm overstepping or I'm not getting something".*

Her response also highlights a latent recognition of the inherent power differential that exists between clinician and client. This was evidenced by her description of verbally informing the client to notify her of any cultural issues that may take precedence or of any boundaries that may have been crossed. Another participant, P6, provides an example of how she directly inquires the client about their cultural factors. In this excerpt we also see P6 verbalizing the consequences of having the authority in the room due to her status as a professional:

> *"Um, so and then my stance is also don't wait for the client to bring it up all the time. As the person who has the power in the room it's important for me to open up the space, discuss culture, by asking open ended questions about values."*

It is important to take a moment here and discuss the importance of the inherent power differential that often exists between client and clinician and its impact on addressing culture in treatment. Research on the ethics of psychological treatment and client-clinician boundaries suggest that clinicians often possess an inherent power in the therapeutic relationship that increases as the duration of the relationship lengthens (Gottlieb, 1993). Smith and Fitzpatrick (1995) discuss five distinct features of the therapeutic relationship that place the clinician in a position of power. First is the "one-way relationship" of treatment. Within Western psychotherapy, the client is expected to share their innermost thoughts and feelings to the clinician, whereas clinicians are often instructed not to self-disclose personal. Second, there is an assumption that clients are in need of more emotional support than the clinician and thus may be more vulnerable to psychological injury, especially as a result of techniques employed by the clinician. Third, if a client wishes to file a complaint against a clinician, the client will have to waive their rights of privacy allowing public examination of the content of therapy. Lastly, healers within many cultures are often recognized as leaders within a community. Given this existence of an inherent power differential it can be assumed that the responsibility to broach culture essentially lies with the psychologist. As described in the participants' excerpts above, broaching culture in session appears to inform the client that if any cultural issue may be a factor in their presenting concern, the client is in a safe space to openly discuss them, even if those cultural issues are not shared by the clinician. This dilutes the power differential by indicating to the client that the therapeutic relationships is collaborative, that the clinician does not know all, and that for treatment to be effective,

the clinician will have to, at times, rely on the client's expertise of their own cultural considerations.

In addition, the participants' responses for this category indicate a necessity for the clinician to initiate the discussion of culture in session. Research suggests that clients who enter therapy with expectations for the clinician to be directive are more likely to develop collaborative and constructive bonds with their clinician especially during the early stages of therapy (Patterson, Anderson, & Wei, 2014). There has been longstanding support in the literature on importance of the therapeutic relationship on treatment outcomes. For example, psychotherapy research has often posited the correlation between common factors such as warmth, empathy, and therapeutic alliance on client outcome (Brown, 2015; Lambert & Barley, 2001). A large meta-analysis conducted on over 200 research reports based on 190 data sources indicated moderate correlations (r= .25-.30) between therapeutic alliance and client outcome (Horvath, Del Re, Fluckiger, & Symonds, 2011). Additionally, Wampold (2015) suggests that in order for certain mechanisms underlying psychotherapy to take effect onto client outcomes, a therapeutic relationship must first be developed. What this body of research suggests is that for psychotherapeutic treatment to produce positive client outcomes, emphasis must be placed on the therapeutic alliance and, to some extent, fulfillment of the client's expectations of a directive clinician. This provides support for the participants' responses of this study suggesting that due to the inherent power differential in client-clinician relationships, and the impact that the therapeutic alliance has on treatment outcomes, there is a responsibility placed on the therapist to instigate conversations about culture.

IV.3.3 Category Three- Application of Culture

This category described the applications of culture as experienced by the participants. Specifically, data within this category defined segments within psychotherapy in which participants found most challenging to incorporate cultural data. Within this category, data showed the emergence of three subcategories that defined these segments within psychotherapy. These subcategories were identified as challenging due to difficulties in the incorporation of cultural data, lack of resources and materials, or a lack of thought in how culture would specifically apply to the segments.

IV.3.3.1 Subcategory One- Assessment

Participants described challenges in utilizing cultural data within assessments due to the lack of availability of culturally-based evaluations. Participants stated that they are aware of the lack of assessments that are normed on culturally diverse populations possibly making the results of these assessments inaccurate for members of minority groups. In an effort to compensate, participants described being "wary" of interpreting assessment results for their culturally diverse clients. Two excerpts from a P1's interview highlight this sense of wariness:

> *"When I did it, I was obviously very, I shouldn't say obviously. I was very wary of a lot things hadn't been normed on a lot of cultures."*

The second excerpt further describes her sense of wariness and concern for lack of culturally normed assessments:

> *"It concerns me because I think so many things, medications as well as assessments, have been normed on white men or white people in general. And then*

I think we're more and more knowledgeable about how things are different. I feel that way for women especially as well, not just certain cultures but gender."

As a result of the lack of culturally normed assessment participants described attempting to interpret results within the context of their client's culture and understanding what cultural factors may play into the results. The excerpt below provides a detailed description P3's method of utilizing cultural data in assessment:

"*Well first of all, um, I certainly think that we have to be familiar with whether certain instruments are normed in the population we want to assess with. Okay, so if there are some instruments that I feel that clients may struggle with, or for example, a lot of intelligence test questions are embedded in the U.S. culture. The questions they ask is very cultural bound in my opinion. So I feel they may have cultural biases so, how do you assess people with learning disabilities that when the IQ has to be you know a certain standard deviation forward than those kind of things. Then it's going to be really hard to assess and interpret what the results might mean. So of course if you use something, before you assess and give it to the client you want to make sure it's some assessment that you feel is valid for this population. Then you have to interpret it with care practically."*

IV.3.3.2 Subcategory Two- Intervention

This subcategory described the participant's experiences in using cultural data to inform selection and utilization of specific interventions. Although similarities existed within this category, two important differences were observed. First was the choice of intervention as dictated by the setting in which psychotherapy was practiced. This appeared to influence the conceptualization of how culture was incorporated into the

participant's intervention. Data showed that participants within private practice and college counseling centers were more likely to use several types of interventions and adapt as needed based on the cultural factors of the client. Those working in specialty clinics described that they were more likely to use one type of intervention while incorporating culture when applicable such as within goal setting and treatment planning. This appeared to be due to limitations established by the settings in which they worked in dictating the types of interventions that could be used (e.g. use of cognitive processing therapy-CPT with combat trauma Veterans) and session time constraints (brief 30-minutes sessions in primary care). P6, who practiced in a college counseling center, describes her method of adapting her interventions to suit the cultural values of her client:

> "*Again I think it goes back to uh, to what I said earlier. Will this intervention fit within this client's cultural background? Like for example I have found that sometimes if someone is from a pretty achievement oriented cultural background, like within their family, um, and competitive oriented, sometimes interventions focused on building self-compassion aren't, won't be as helpful because that's just not their personal value. That's not how they talk to themselves. So I adapt that. You know, I do want them to be less critical of themselves but instead of focusing on being self-compassionate I think of a way where they can be less critical but still adhere to their cultural value of competition and achievement".*

An example s from P7, who is established in private practice, describes his method of utilizing different interventions based on the individual cultural factors of the client:

> *"Well I mean I think it's effective to you know, to look at which interventions may be most effective with, with broader cultures. Um, again I caution, I think culture is*

so poorly defined and uh, there's no consistency between studies even in, into what they're calling culture. Uh, you know that you have to be so very careful about that. You know, that's why I always come back to look at the individual. I mean the individual maybenefit even if they come from this culture. Um, I do think the thing that's relevant is you know if there is a history that this intervention is not effective with this particular culture, then one may want to progress very cautiously. Or at least check out whether or not it is even acceptable. You know for this uh, this person to participate in this kind of thing."

P5, who practices in a specialty VA clinic treating Veterans with combat trauma through the use of an evidenced based treatment (CPT), describes her experiences of using cultural data within the environment she works in:

"Mm, I have less, hm, I guess that is, that's a good question. So since a lot of what I'm doing is brief treatment there are certain evidence supported treatments that are going to work well in that format and in that environment. And um, so I guess the thing that I'll try to do is maintain awareness of some therapies that work well with the population that we treat. Some is what the evidence kind of shows, but also will fit into treatment environment in which I work."

The second difference found in the data show the method of cultural data utilization in intervention varied by the theoretical orientation used. Participants who described their theoretical orientation as more strictly aligning with one orientation over the other did not appear to change the use of existing skills and techniques related to that particular theoretical approach. Rather they infused culture at different points of psychotherapy such as within case conceptualization or treatment planning and allowed for space for discussion

about cultural factors. Participants who appeared to utilize more integrative orientations were more likely to change their approach to interventions completely if it became culturally relevant to do so. An excerpt below from P2 who identified herself as using a Cognitive Behavioral Therapy (CBT) theoretical approach describes her thoughts on how cultural data informs her selection of intervention:

> *"I just don't know how I would um, so I'm thinking about two of my clients here. I'm thinking about the transgendered lady and um, my African American female who was dealing with grief. If I'm going to do CBT, CBT is going to look the same. It'll be a little bit different because there will be different distortions I'm working on, right. Or belief systems or schemas. Um, it ain't changing that much. And if I'm doing trauma work it ain't changing that much."*

P7, who described himself as utilizing a more integrative theoretical approach, expressed his use of cultural data in intervention by retelling a discussion he had with a previous client:

> *"But you know she said you were always shifting styles of therapy in order to respect the goals that I had created for myself. Um, and so if you thought one better style was going to work, you know, you would just switch and transform into that style. Um, and, and so she would say that that's what allows me uh, to transcend culture. Is that, you know, you are fluid.*"

Data from this subcategory showed that participants in this study did utilize cultural data into their interventions. However, as can be seen in the previous excerpts, the method and process by which they used cultural data in their interventions differed based on the setting of practice and their theoretical orientation.

IV.3.3.3 Subcategory Three- Outcome Evaluation

This subcategory described the experiences of the participants as they attempted to incorporate cultural data into therapeutic outcomes. In general, all eight participants described use of cultural data in outcome evaluation to be challenging. This appeared to be due to the lack of evaluative materials that incorporated culture, similar to the challenge posed by assessments. Due to this lack of culturally sensitive evaluation materials, participants described the use of a combination of broad quantitative materials measuring common psychological symptoms such as depression, anxiety, or posttraumatic stress disorder (PTSD) and subjective evaluations such as client self-disclosed improvement in psychological and emotional functioning, client's perception of progress towards goals, and observations in behavior outside of therapy as reported by the client and psychologist. P5, who works at a specialty PTSD VA clinic, described her experience of using the PTSD Check List (PCL) as an outcome measure with female veterans who experienced military sexual trauma (MST):

> *"Because I don't necessarily think that the PCL really taps into what we're really lookingat. It is PTSD but women exhibit these things sort of differently. And so while I think the PCL is great for male combat veterans or even necessarily female combat veterans with MST it misses the mark and so we have the conversation in completion of CPT. Specifically individually um, that this isn't really the best measure. We don't think, to try to get what we're getting at. And I will also, now that I'm thinking about this, I've had some clients whose PCL didn't change much at all. Um, and we've had conversations about why. And often it's that they've had such severe trauma throughout their entire life that it's not really realistic to expect*

that like okay this changed my entire life and now I'm better. And so sometimes people's scores go up. And so we, instead of talking about the quantitative side of things, we start talking about the qualitative side of things and how this isn't the finish line."

In this excerpt we see that P4 recognizes the evaluative issues within the main outcome measure used in her clinic. Specifically she addresses the difference in psychological presentation of PTSD within female and male veterans and how the clinic's outcome measures, the PCL, does not appear to capture the unique nuances of female veterans who have experienced MST. Moreover, she continues to state how the severity of a client's trauma can impact their perception of improvements and thus also impact the accuracy of the PCL results. This appears to also determine which elements of treatment outcome, quantitative or qualitative, are assessed.

P6 who works in a college counseling center describes her method of evaluating outcomes utilizing more subjective means:

"Um, again I think it depends but if I were to broaden that I would it is uh, is the client satisfied and not experiencing anxiety. Um, so is what their treatment progress is going towards is that helping them feel more at peace and at ease where they're at while also adhering to their personal value system."

In another expert by P3, we see her description of how evaluating outcomes can be achieved in multiple ways:

"So I know I'm not articulating these um, very well, but I think a bigger part of it is really, uh, whether, uh, whether they improved, and improved of course, we can

evaluate it many different ways. You know, so you can be subjectively, it can be self-report. It can be objective. It can be a lot of different ways."

P3 also goes on to describe her thoughts on how achievement of the client's goal is tied to incorporating culture in outcome evaluation:

"But a lot of times, how is that compared to the therapy goals? That whether we have achieved those therapy goals. So, whether we have helped client and achieved their goals….So how is that tied to culture? I don't, I still think that all the programs and services and working with clients, if you put such culture centered, then your outcomes will be tied into the knowledge. Because of different level of cultural competencies. So the more you have those specific cultural competent knowledge, then your service can be really addressing those issues. So as a result, that comes very naturally. The outcome is going to be you know, it's going to be more effective as a result because of all the specific things that you address."

Participant 3 described her incorporation of culture in outcome as being tied to the goals she develops with her clients. For P3, if goals have involved and included the client's cultural variables and factors, then if those goals are achieved then, inherently, culture has also been included within outcome evaluation.

IV.4 Summary of Findings

In summary, results of this study indicated the emergence of three major categories. The first, nature of cultural competence, described the essence of cultural competence which participants viewed as fluid, on-going, and a process that, when in its true form, can never truly be achieved. This first major category yielded two subcategories. Subcategory one, a willingness to learn, provided a description of an attitude participants' saw as

necessary to for cultural competence. This attitude encompassed not only openness to new information but also a latent intention to seek out culturally relevant knowledge. Subcategory two was differentiated into two elements, A and B. Subcategory two-A, knowing what you do not know, defined an awareness of one's own gaps in knowledge. Participants' described this awareness as necessary to facilitate cultural competence and seek the appropriate information, whether it is from the client or from other resources. Within this category, four separate subsets emerged, describing methods in which clinicians can close this gap of knowledge once it has been recognized. These were identified as: 1) asking the client and creating space for discussion about culture; 2) not assuming or possessing flexibility in cognition about the client's cultural background and experiences; 3) recognizing that the gathering of client cultural data is a process that begins at intake and unfolds throughout the therapeutic process; and 4) meaningful cultural knowledge is best gathered through interaction with clients, immersive experiences, intentionally sought out workshops and continuing education credits, and through the self-reflection or self-directed research. Subcategory two-B, not knowing what you do not know, depicted an awareness that a clinician cannot feasibly be competent in all cultural variables. Participants identified two specific implications of this lack of awareness of the gaps in one's own knowledge. The first is that it results in the risk of misattributing cultural factors onto the client. Second, this lack of awareness was described to transcend into parts of the self, such as values, biases, and judgements that may be interacting with the client and overall treatment. The second major category to emerge, the role and responsibility of the therapist, identified the necessity for clinicians to broach and initiate topics of culture in session as they pertained to the client's concerns. This responsibility

stemmed from the inherent power differential between client and clinician that often exists in therapeutic contexts. Broaching culture in session was viewed as method in which this power differential could be diluted, allowing for the client to feel more comfortable and provide further information. The final major category to emerge, application of culture, outlined three segments of psychotherapy in which participants described having the most challenges with. Each of these segments were separated into a subcategory, The first subcategory, assessment, described the participants' recognition that many commonly used psychological assessments were normed on a homogenous population, white men. They described wariness in their interpretation of assessment results and difficulties with incorporating culture into this segment of psychotherapy due to a lack of culturally sensitive assessment materials. The second subcategory, intervention, described the participants' experiences in using cultural data to inform intervention selection and utilization. Within this subcategory, data showed differences in how cultural data was incorporated based on theoretical orientation and limitations of the practice setting. The last subcategory to emerge, outcome evaluation, highlights the difficulties of cultural data incorporation within outcome evaluations. Participants described the lack of culturally sensitive outcome evaluations and thus, would use a combination of objective and subjective measures to track progress in treatment. A visual representation of these findings is shown in Figure 1 on page 64

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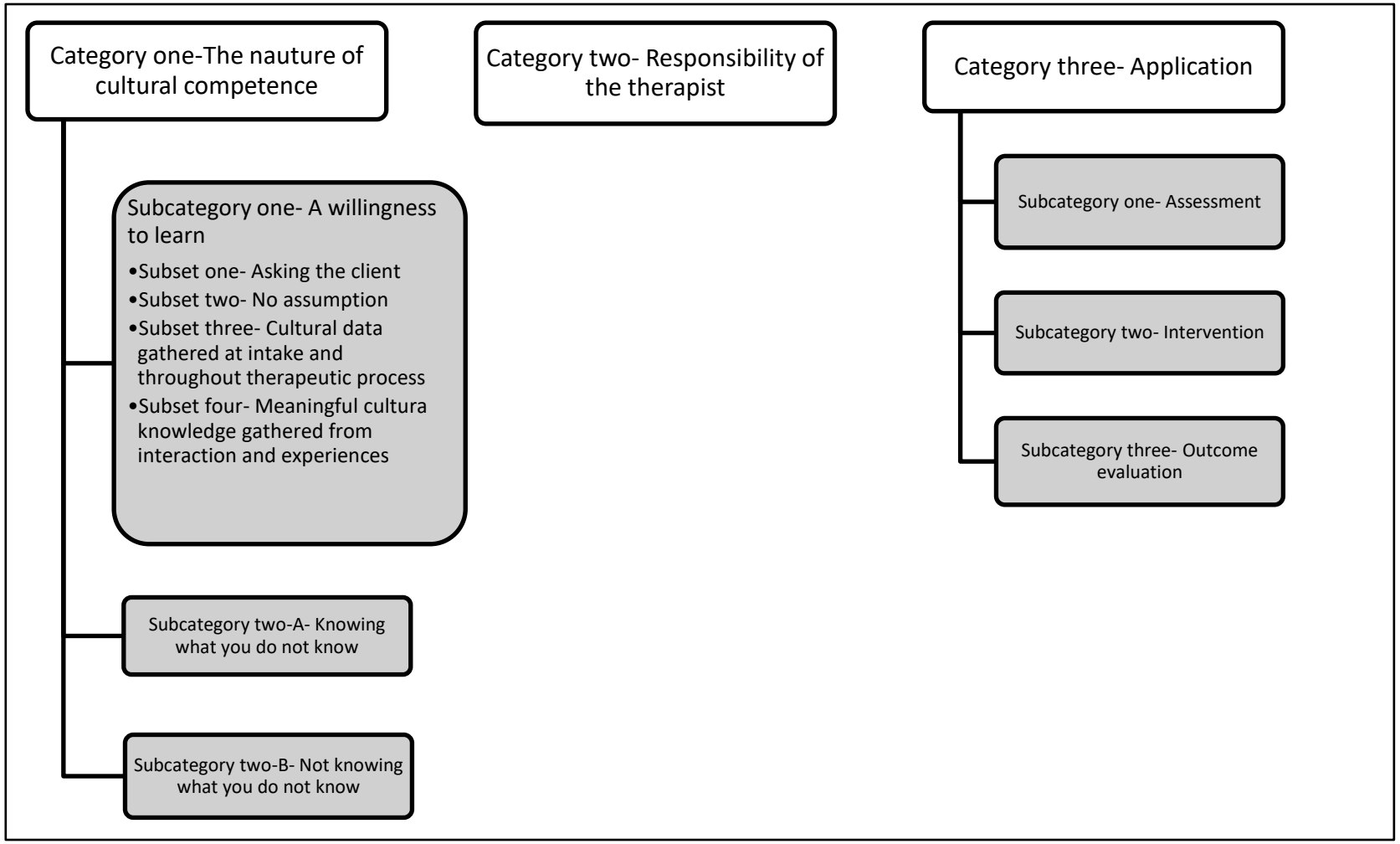

Figure 1. Visual representation of themes

CHAPTER V

DISCUSSION & CONCLUSION

This study was conducted to understand how psychologists utilize cultural data in their psychotherapeutic practices. This section will first discuss the context within which the study was conducted and the reflective experiences of the researcher. Next, connections between results and the literature will be expanded on focusing on implications of this study. Finally, this section will present study limitations and recommendations for future research.

V.1 Reflective Experiences of the Researcher

The aim of this study was to come to a greater understanding of how licensed and practicing psychologists utilize cultural data in their case conceptualization and overall psychotherapy. Given the paucity of research on the understanding of the application of cultural data in psychotherapy, a phenomenological method was chosen. Phenomenological methods require the researcher to be aware of the context within with the study is situated in. Lincoln and Guba (1985) describe the value-laden nature of phenomenological methods and the importance of the researcher to understand their role in participant interaction, data collection, and data analysis. For this reason I maintained a reflexive journal of each interview I conducted as well as my thoughts and reactions between interviews to better facilitate the data analysis and descriptive construction of the phenomena.

Prior to beginning any interviews, I was ardently aware of my existing knowledge of the psychotherapy process and how I utilize this with my own clients. Although the

same interview protocol and question order was used with each participant, as a researcher I recognized my role in asking probing questions and how this could influence the trajectory of the interview and thus the data collected. As a result, I maintained focus on the content provided by the participant and based my probing questions on my clarity of understanding of their response. This sense of hyperawareness also applied to my existing knowledge of cultural competence and my individual application of it in therapy. As a result, I was also careful to use the participant's terminology as opposed to my own when asking for clarification through paraphrasing. This was in an effort to withhold the transference of my assumptions and values onto the participant's responses.

During the interview process I became aware of another possible influence on the participants' responses; the sense that participants may feel forced to provide a specific answer due to stigma within the academic and practice communities placed on psychologists who may not incorporate culture into their psychotherapeutic practices. Although none of the participants expressed any discomfort or resistance to answering the interview questions, if their response to a question indicated that they did not know how or did not use cultural data within a segment of psychotherapy, I found myself having an urge to explain that it was not an issue and that I was simply looking to see how they did or did not utilize it. Upon using my reflective journal it came to my attention that my urge to placate the participants may be a reflection of my own biases of individuals who do not incorporate culture into their practice. Upon this realization I began to identify when I had these urges to "soothe" a participant and refrained from doing so.

Similar to the reflections, during data analysis I was very aware of my knowledge on the topic of cultural competence and how it may influence not only the data collected

but how the data were analyzed. As such, I found it important to be cognizant of my experiences with cultural competence and how they may be influencing data coding such as identifying units, categories, and themes. To buffer these effects I read through the transcripts multiple times to ensure that the units I was identifying were emerging from the data rather than from my experiences, biases, and assumptions. Lastly, I was also aware of the relationships I had with some of the participants as a colleague or supervisee and how it may be impacting the responses provided to me.

V.2 Discussion of Findings

Results of this study indicated the development of three categories. Two of these categories, the nature of cultural competence, and responsibility of the therapist, highlighted the essence of cultural competence. Specifically, they shed light on the attitudinal, behavioral, and cognitive processes that participants described as necessary for the facilitation of cultural competence. The first category, nature of cultural competence, defined the on-going, flexible, and process-oriented nature of cultural competence. Participants described cultural competence as a process that, when in its truest form, can never truly be achieved. This requires psychologists to recognize cultural competence as a concept that requires continuous learning. The first subcategory to emerge underscored the method by which a clinician could work towards cultural competence- a willingness to learn. Participants described a willingness to learn as incorporating openness to new information and a latent intention to seek culturally relevant knowledge.

The second subcategory to emerge contained two segments. The first, knowing what emphasized the importance of possessing awareness of one's gaps in knowledge. Participants further described four methods by which this gap in knowledge could be

addressed once awareness was established. These methods formed four individual subsets of the subcategory. The first included asking the client as a technique to make the unknown known. The second subset emphasized not assuming the client's cultural experiences and background as a cognitive technique in flexibility of thought. The third subset portrayed the gathering of cultural data to occur at the intake and throughout therapy indicating that data can often unfold over time. The fourth and final subset illustrated the best methods in which meaningful cultural data could be gathered by clinicians- through personal interaction and experiences rather than traditional textbook-means. The second segment of subcategory two involved the issue of clinicians not knowing what they do not know. In other words it described a lack of insight into their gaps of knowledge which inherently resides within psychologists. This exemplifies the view that a psychologist cannot be competent with all possible cultural factors.

The second category to emerge from the data highlighted the role of psychologists and the responsibility they possess to broach the topic of culture in session and engage the client in an open-ended discussion. Participants discussed the inherent power differential that often exists between client and clinician and the impacts this makes on the client's comfort to discuss their unique cultural factors that may be playing a role in their psychological presentation. The final category to emerge from the data outlined three areas of intervention in which participants found most challenging to incorporate cultural data. These three areas were developed into three separate subcategories. The first, assessment, indicated the challenges participants faced with incorporating culture into assessing symptoms due to a general lack of culturally sensitive assessment materials. The second subcategory described challenges faced in intervention due to the nature of intervention

being used and setting limitations such as time and session parameters. The final subcategory to emerge from the data described the difficulties of incorporating culture into outcome evaluation due to, again, a lack of culturally sensitive materials. Here, participants described using a combination of objective and subjective evaluative methods to assess for outcome status.

V.3 Connection to the Literature and Implications

Several factors define the importance and need of cultural research within psychotherapy. First, culture is a phenomenon that pervades all aspects of psychotherapy. Draguns (1973) identified culture as a silent partner in psychotherapy, emphasizing its ubiquitous nature and tendency to be overlooked within process and outcome. Second, humans are cultural beings with culture pervading all aspects of human life. This indicates that individuals develop within a cultural context with its impact resonating in psychological presentations. Third, mental health care disparities and racism in the mental health delivery system are firmly established with inequities in assessment and diagnosis, selection of interventions, assignment of clinicians based on status, premature termination, and dissatisfaction regarding treatment experiences of ethnic minorities (Cook, McGuire, & Miranda, 2007; Cook et al., 2014; Ridley, 2005). Additionally, although multicultural research has significantly progressed in recent decades, little is still known on how cultural dynamics are executed in psychotherapy sessions (Owen, 2018). Recognizing this paucity in research, this study was developed utilizing a phenomenological approach. Phenomenology is a branch of qualitative methodology that aims to examine the lived experience of specific psychological phenomena. Its goal lies in the development of an understanding of the cognitive and affective processes within these phenomena (Percy,

Kostere, & Kostere, 2015). Thus, it is best used to answer questions that require a greater depth of understanding. Within this study, attitudes, thoughts, beliefs, opinions, and feelings about how psychologists incorporate cultural data into their psychotherapeutic practices were investigated. This section will discuss the findings' connection to existing literature and explore the implications of the cognitive and affective processes of cultural data incorporation into psychotherapeutic practice.

Beginning with the depiction of cultural competence, participants' description of this construct as a process that is fluid and flexible shares some similarity to the concept of dynamic sizing as defined by Sue (1998). Dynamic sizing is described as a clinician's ability to possess the appropriate knowledge and skill necessary to understand when to generalize or individualize cultural information to the client or when to be exclusive. Participants in this study appeared to echo similar sentiments when describing cultural competence as a process that requires constant flexibility and fluidity. Participants described this flexibility and fluidity as recognition of when certain cultural data fit within their client's context, when it did not, and what internal and external factors impact this data. Implications of this finding suggests that a tension exists in psychotherapy when managing within-group and between-group differences. This suggests a challenge in being able to strike a balance addressing the client's larger cultural values and beliefs with their unique method of embracing the treasured aspects of their culture. Although Sue's (1998) model speaks to this challenge, it does not provide direction on its application within psychotherapy.

The portion of the participants' descriptions that Sue's Tripartite Model (1992) does not describe, however, is that of the never achievable quality of cultural competence.

While Sue's model does offer a foundation from which cultural competence can be conceptualized and built upon and has greatly added to the field, little is still known on how these characteristics and dimensions can be applied in psychotherapy. Participants of this study describe use of techniques similar to those outlined in the Tripartite Model such as awareness of one's own assumptions, attempts to understand the client's worldview without negative judgment, and development of appropriate interventions techniques. However, the participants' descriptions appear to go beyond what the model provides by labeling cultural competence as "never finished" or never completed. This aspect of cultural competence was portrayed by participants as a process that is never truly achievable if one is to be culturally competent. This is to say that if a psychologist was to believe that they have achieved cultural competence then that belief in and of itself renders them incompetent because it leaves them less likely to gather, learn, and incorporate new cultural data. Implications of this finding suggest that current models of cultural competence do not capture the entire essence of the construct. Specifically, they do not capture the idea of cultural competence as being on-going and never truly achievable. An example of this can be found in the results from a systematic review on cultural competence measures conducted by Kumas-Tan, Beagan, Loppie, MacLeod, and Frank (2013). One of the several problematic themes found in the study indicated that the current views of cultural competence was that of a construct that could be achieved by having sufficient knowledge and awareness of cultural groups. This poses implications on clinician training. If current models do not accurately encapsulate the on-going characteristic of cultural competence, this invariably impacts how clinicians are trained to

think, feel, and behave towards culture. This ultimately impacts how cultural data gathered, synthesized, and incorporated into psychotherapy treatments.

Moreover, this implication suggests that cultural competence demands life-long professional learning. Due to the diversity of individuals and the multifaceted and complex nature of cultural competence, it would be irresponsible to consider that a clinician could master this complexity. However, although cultural competence in all its fullness and complexity is unachievable, it is important to note that certain thresholds or levels of cultural competence can be achieved. This is to say that an increasing threshold of cultural competence can be achieved over time. For example, a clinician's cultural competence threshold 20 years after licensure is surely, if continuously progressing towards it, much higher than their threshold two years after licensure. This suggests that although mastering cultural competence in all its intricacies may be unachievable, progressing towards higher thresholds of this competence is achievable and should be acted upon.

Another implication of findings from this study stems from the theme that described the importance participants placed on not assuming the client's cultural background and experiences. In other words, participants described a form of cognitive flexibility that is necessary for cultural competence. Although research shows support for the adaptation of one's own thoughts and actions when studying cultural competence, the field still lacks research on what those adaptations need to be (Chiu and Hong, 2005). More specifically, there is a paucity of research to indicate the cognitive processes required for the adaption of thoughts and actions in relation to cultural competence. Current concepts that may broadly fall in the realm of cognitive processes include cultural humility and cross-cultural empathy (Dyche and Zayas, 2001; Trevalon and Murray-Garcia, 1998).

However, cultural humility and cross-cultural empathy may not be an exhaustive list of all the cognitive processes that results in cultural competence.

Although the field is knowledgeable of the microskills needed for therapeutic practice (e.g. active listening, reflections, empathy, attending etc.) what it does not do well with is the teaching of the thought processes required for cultural competence. Questions that still require an answer and emphasize the cognitive processes important in cultural competence include: How do we determine what cultural data to gather? How do we sort through cultural data? How do we organize cultural data to determine what is most relevant to the client? How do we decide if the data supports a healthy clinical picture based on the client's culture or if it points in the direction of psychopathology?

One other implication of this study emerges from the concept of cultural competence requiring not only a willingness to learn and openness to new information, but also an intention to seek out culturally relevant knowledge. While studies cite knowledge of a cultural group to be one of the components of cultural competence, few discuss the concept of intention and its role in the accumulation of cultural knowledge (Gainsbury, 2017; Quershi & Collazos, 2011; Wendt & Gone, 2011). Shortage of research on this concept has implications for the clinical training of psychology graduate students as well as consultation and continuing education for current licensed practitioners. For psychology trainees, Lee and Khawaja (2013) discuss the development of relevant knowledge and skills for psychotherapy as primarily gained through supervisory experiences. Moreover, Fukuyama (1994) discusses the importance of openness and support from supervisors to help trainees with multicultural psychotherapy. What this research suggests is that supervision may be a place to nurture the development of

intention to seek culturally relevant knowledge for psychology graduate students. For clinicians already in practice Jones, Begay, Nakagawa, Cevasco, and Sit (2016) suggest that consultations are one method by which support and guidance for work-related difficulties can be discussed. Moreover, their study indicated increased levels of measured cultural competence over time for participants who received consultation that included a focus on cultural factors. Thus, if inclusion of cultural factors can result in increased measured levels of cultural competence, then the addition of developing intentionality within consultations may prove to be beneficial.

Another implication from this finding is the movement from being a student of cultural knowledge through possessing attitudes of willingness, openness, and intention to one that translates this knowledge into practice. Although participants recognized the importance of gathering cultural knowledge and data, what their responses lacked was a description of how they translated that information into practice. This shows that the data from these participants had less emphasis on the process of interpreting and translating cultural knowledge into practice. This implicates training within the field and the emphasis placed on the process of translating cultural knowledge and data into practice.

Results from this study also implicate the therapeutic relationship, its inherent power differential, and their combined impact on the incorporation of cultural data into psychotherapy. Prevailing research in health care disparities emphasize the role of the client-provider relationships and its importance on culturally competent care (Beach, Saha, & Cooper, 2006). Results from this dissertation study suggest that the responsibility placed on psychologists to broach culture in psychotherapy is a component of the client-provider relationship and is directly related to the level of authority a clinician has in session with

their client. As discussed in the results, a psychologist's decision to address culture in session can impact the client's response to treatment and their willingness to disclose clinically relevant information. Despite this importance, little research and training exists on how psychologists can appropriately and effectively introduce culture in session.

The final implication of this study revolves around the modulation of cultural data incorporation based on theoretical orientation and practice setting. Although some research indicates that culture is often reflected across all psychotherapeutic theories, participants in this study suggested differences in how culture can be reflected and incorporated (Pope-Davis, Liu, Toporek, & Brittan-Powell, 2001). The form-content dichotomy theory, developed by Rajesh and Jacob (2004), may provide partial explanation for the participants' responses. Form-content dichotomy highlights the notion that a clinician can emphasize the form or structure of therapy provided or the content of therapy. Rajesh and Jacob suggest emphasis on form allows for clinicians to identify behavioral syndromes across cultures while emphasis on content may only help identify symptoms that reside within a specific cultural context. The degree to which focus is on form or content in therapy may be provide more insight into the differences of cultural data incorporation described by participants.

V.4 Recommendations for Future Research and Practice

Although there is a considerable amount of research in multicultural assessments, this body of work has not yet yielded instruments and techniques that clinicians can readily use within their practices. Recommendations for future research include the development of instruments that that can help increase the availability and access of good assessment techniques for practitioners. Relatedly, the field would also benefit from developing

culturally sensitive psychological screeners by intentionally incorporating more minority participants in scale development studies. This will aide in identifying various cultural factors that impact symptom presentation.

Future research should include the development of treatment outcome evaluations that incorporate cultural factors. As described by participants, due to the lack of culturally sensitive outcome measures it was common for outcome to be evaluated through the use of objective and subjective methods. As a result, further research on identifying cultural variables that impact treatment outcome would be beneficial.

Additionally, use of explorative studies to understand the subjective nature of treatment outcome or progress for culturally diverse clients would add to the field. These explorative studies would inform clinicians on how to assess the subjective responses of treatment progress provided by clients.

The cultural competence literature can be enhanced by assessing the moderating effects of theoretical orientation and practice setting on the level of cultural data incorporation. This would aid in distinguishing barriers to cultural data incorporation as well as provide insight on methods to increase the feasibility cultural data inclusion into psychotherapy.

Recommendations for practice are three-fold. First is the development of specific techniques to help clinicians broach the topic of culture in session. Specifically, clinicians would benefit from the development of open-ended questioning techniques and skills to maintain meaningful discussion about the client's culture while utilizing a non-judgmental approach. Second is the development of innovative, immersive, and interaction-based experiences to help clinicians gather more meaningful cultural knowledge. This would

require graduate training programs, local and national professional psychological associations, and continuing education workshops to re-assess their method of providing cultural knowledge to students and current clinicians. Third, the field would benefit from the development of conceptual models that better explicate the process of gathering, interpreting, and integrating cultural data in psychotherapy including the cognitive and behavioral aspects of this process.

V.5 Limitations

Several limitations of this study may have impacted results. First, this study had a small sample size. A sample size of 12-15 was initially indicated for this study. However, due to significant difficulties in recruiting and scheduling, only eight participants completed the interview process. Difficulties in recruiting involved low response rates after dissemination of recruitment flyers and materials. This researcher made repeated efforts to contact the local professional organizations listed earlier in this paper in an attempt to recruit participants. However, despite these attempts response rates were low. After these attempts, this researcher and her PI utilized their network of professional contacts to recruit participants. A smaller sample size may suggest that the full extent of detail and richness about the phenomena being studied may not have been collected. The small sample size may have been attributed to the prolonged length of engagement that was required by participants for the interview (one to two hours). Additionally, phenomenological approaches have a tendency to unearth deep issues, some of which may not be comfortable for participants to discuss (Lester, 1999). Given that culture has been recognized as crucial within mental health treatment, the gravity of the phenomena being explored in this study may have resulted in a lower number of responses to recruitment efforts. Second, seven out

of the eight participants had some form of a relationship with either the researcher or principal investigator. This may have resulted in motivational bias factors. Montibeller and Winterfeldt (2015) define motivational bias as conscious or subconscious distortions in judgments or decisions due to factors of self-interest, social pressures, or organizational context. The existing relationships may have created social pressures for the participants to volunteer. A third limitation that may have impacted the results are the effects of demand characteristics which are defined as a form of problem-solving behaviors in which a participant in a study attempts to provide responses that satisfies the goal of the study or researcher (Orne, 1962). Within the context of this study, demand characteristics may have exhibited itself in the responses provided by participants. For example, participants may have felt compelled to provide much more in-depth responses to their utilization of cultural data in psychotherapy than their actual use of cultural data in practice. Participants may have also provided answers so as to avoid any stigma that may be associated with the lack of cultural incorporation in mental health treatment. Lastly, the questions developed for the interview protocol utilized the Tripartite Model of Cultural Competence (Sue, 1982). Use of a specific model to develop questions for this study may have bound the content of responses within the Tripartite model frame work or altered the trajectory of the interview itself. As a result, use of a different model or no model at all could have altered the properties of the categories, their organization, or even the development of new categories that did not appear in this study.

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APPENDIX A

ELECTRONIC RECRUITME FLYER

Greetings,

My name is Shruti Surya, and I am a counseling psychology doctoral candidate working under the supervision of Dr. Charles Ridley at Texas A&M University. We are looking for **current licensed and practicing psychologists** to participate in a study exploring how psychologists incorporate culture into their psychotherapy. Participants **must** meet the following criteria:

1. The participant must be currently licensed and practicing as a psychologist.
2. The participant's workload must involve at least 50% direct client contact through psychotherapy.
3. The participant must have experience practicing in mental health settings with a diverse population and thus, have had some clinical encounters with racial, ethnic, and other minority individuals.

The study involves a 1-2 hour audio recorded interview and confirmation of the transcribed responses via email once transcription has been complete. Interviews can be conducted in person or through Skype video conferencing. All participants will receive a **$50 VISA gift card** as compensation. For participants who complete the interview through Skype video conferencing, a mailing address will be requested to send compensation.

If you or someone you know are interested in participating or have any further questions, please email ssurya2 @tamu.edu or call (847)530-7102 for more information.

Thank you for your interest!

Shruti Surya, M.A.
Counseling Psychology Doctoral Candidate
Texas A&M University

IRB NUMBER: IRB2017-0240M
IRB APPROVAL DATE: 05/05/17
IRB EXPIRATION DATE: 05/01/2022

APPENDIX B

STUDY INFORMATION EMAIL

Dear Dr.XXXX,

You are receiving this email because you expressed interest in participating in a study that explores how psychologists incorporate culture into their psychotherapy. The study is qualitative in nature and involves a semi-structured interview. Your participation would involve a 1-2 hour audio recorded interview and a follow-up email to validate the content of the transcribed interview. The interview may be completed in person or through Skype video conferencing. Upon completion of the interview, you will be compensated for your time with a $50 VISA gift card. If you choose to be interviewed through Skype video conferencing, a mailing address will be requested to send compensation. All personally identifiable and 3rd party information will be de-identified and coded to protect your privacy, confidentiality, and safety.

To be able to participate in this study, I will first need confirmation that you meet the following inclusion criteria:

1. The participant must be currently licensed and practicing as a psychologist..
2. The participant's workload must involve at least 50% direct client contact through psychotherapy.
3. The participant must have experience practicing in mental health settings with a diverse population and thus, have had some clinical encounters with racial, ethnic, and other minority individuals.

If you meet the above criteria and are interesting in participating, please reply to this email. To best accommodate your schedule and assure your privacy and comfort during the interview process, I would be more than glad to schedule a date and time of your preference.

Please feel free to review the attached informed consent document which provides more information about the study and your privacy and confidentiality. If you have any questions, comments, or concerns please do not hesitate to contact me through email or, if preferred, by phone at (847-530-7102). For participants who choose to complete the interview over Skype, you will also be given an opportunity to address these questions and concerns at the time of the scheduled video call prior to beginning the interview.

Thank you for your time.

Regards,
Shruti Surya, M.A.
Doctoral Candidate- Counseling Psychology
Texas A&M University
Department of Educational Psychology
shruti.surya7@gmail.com
ssurya2@tamu.edu

APPENDIX C

INFORMED CONSENT DOCUMENT

INFORMED CONSENT DOCUMENT

Project Title: Psychologists' Incorporation of Cultural Data in Psychotherapy: An Exploratory Study

You are invited to take part in a research study being conducted by Shruti Surya, M.A., a researcher from Texas A&M University and funded by The College of Education and Human Development at Texas A&M University. The information in this form is to help you decide whether or not you would like to participate. If you decide to participate in the study, you will be asked to sign this consent form. If you decide you do not want to participate, there will be no penalty to you, and you will not lose any benefits you normally would have. You may choose to leave the study at any time without penalty. NOTE: If you are employed then it is your responsibility to work with your employer regarding time off for participation in this study if during work hours.

Shruti Surya, M.A.
Ssurya2@tamu.edu
847-530-7102

Why Is This Study Being Done?
The purpose of this study is to gather information on how psychologists use culture in psychotherapy. Competent use of culture has become recognized as being important to effective psychotherapy. The findings of this study will help determine the extent to which psychologists actually put multicultural theory and research into practice. This information will be used to advise and improve graduate level training and continuing education in applied psychology.

Why Am I Being Asked To Be In This Study?
You are being asked to be in this study because you have confirmed that you meet the following criteria:

1. You are a current licensed and practicing psychologist.
2. Your work load involves at least 50% of direct client contact through psychotherapy.
3. You practice in mental health settings with a diverse population and as a result, have had experience and with encounters with racial, ethnic, and other minority individuals.

How Many People Will Be Asked To Be In This Study?
A maximum of 15 people will be invited to participate in this study locally.

What Are the Alternatives to being in this study?
The alternative to being in the study is not to participate.

What Will I Be Asked To Do In This Study?
You will be asked to answer questions about your use of cultural information in psychotherapy. Your participation in the interview will last 1-2 hours. The interview will be conducted in person or through Skype video conferencing. You will be sent an email after transcription of the interview has been completed. In this email you will be asked to confirm the transcription of your responses. This study will only need one visit.

INFORMED CONSENT DOCUMENT

Will Photos, Video or Audio Recordings Be Made Of Me during the Study?
The interview will be audio recorded. The researcher will tell you when the recording will begin and end. The audio recording will be used to transcribe and code your responses for analysis. If you do not give permission for your interview to be audio recorded, you cannot participate in this study.

_____ I give my permission for audio recordings to be made of me during my participation in this research study.

Are There Any Risks To Me?
The things that you will be doing have no more risk than in everyday life. Although the researchers have tried to avoid risks, you may feel that some questions are stressful or upsetting. You do not have to answer anything you do not want to. If needed, you will be given information about individuals and/or organizations that may be able to help you with these problems.

Are There Any Benefits To Me?
By being in this study you will benefit from organized self-reflection.

Will There Be Any Costs To Me?
Your time will be the only cost to you.

Will I Be Paid To Be In This Study?
You will be paid for this study after the interview has been completed. The interview must be completed in order to receive payment. There is no partial payment. If the interview has been completed through Skype video conferencing, a mailing address will be requested to send the VISA gift card.

Will Information From This Study Be Kept Private?
The records of this study will be kept private. No information linking you to this study will be included in any sort of report that might be published. Any identifying information about you or other individuals that you share with the researchers of this study will be de-identified and coded. Research records will be stored securely and only members of the study team will have access to this data. Recordings will be transcribed as soon as possible by the research team. Audio files will be destroyed 3 years after this study has been completed.

Information about you recorded in audio or on paper will be stored in a locked file cabinet within a locked office on Texas A&M University property. This consent form will be filed securely in an official area.

The Principal Investigator and research study team will have access to your information. Representatives of regulatory agencies such as the Office of Human Research Protections (OHRP) and entities such as the Texas A&M University Human Research Protection Program may access your records to make sure the study is being run correctly and that information is collected properly.

The agency that funds this study (College of Education and Human Resources at Texas A&M University) may also see your information. However, any information that is sent to them will be coded with a number so that they cannot tell who you are. Representatives from these entities can see information that has your name on it if they come to the study site to view records. If there are any reports about this study, your name will not be in them.

Information about you and related to this study will be kept confidential to the extent permitted or required by law.

Who may I Contact for More Information?

You may contact the Principal Investigator, Dr. Charles Ridley, Ph.D. to tell him about a concern or complaint about this research at 979-862-6584 or cridley@tamu.edu. You may also contact the Co-Investigator, Shruti Surya, M.A. at 847-530-7102 or ssurya2@tamu.edu.

For questions about your rights as a research participant or comments, complaints, or concerns about the research you may call the Texas A&M University Human Research Protection Program (HRPP) by phone at 1-979-458-4067, toll free at 1-855-795-8636, or by email at irb@tamu.edu. This informed consent form and all study materials should include the IRB number, approval date, and expiration date. Please contact the HRPP if they do not.

What if I Change My Mind About Participating?

Your participation in this research is voluntary, and you have the choice whether or not to be in this research study. You may decide to not begin or to stop at any time. There will be no effects if you choose not to be in this study. Any new information about the research will be given to you. This information could affect your decision to continue your participation.

TEXAS A&M UNIVERSITY HUMAN RESEARCH PROTECTION PROGRAM

INFORMED CONSENT DOCUMENT

STATEMENT OF CONSENT

I agree to be in this study and know that I am not giving up any legal rights by signing this form. The procedures, risks, and benefits have been explained to me, and my questions have been answered. I know that new information about this research study will be provided to me as it becomes available and that the researcher will tell me if I must be removed from the study. I can ask more questions if I want. A copy of this entire consent form will be given to me.

_____ _____

Participant's Signature Date

_____ _____ _____

Printed Name Date

INVESTIGATOR'S AFFIDAVIT:

Either I have or my agent has carefully explained to the participant the nature of the above project. I hereby certify that to the best of my knowledge the person who signed this consent form was informed of the nature, demands, benefits, and risks involved in his/her participation.

_____ _____ _____

Signature of Presenter Date

_____ _____ _____

Printed Name Date